The Public Health Nurse

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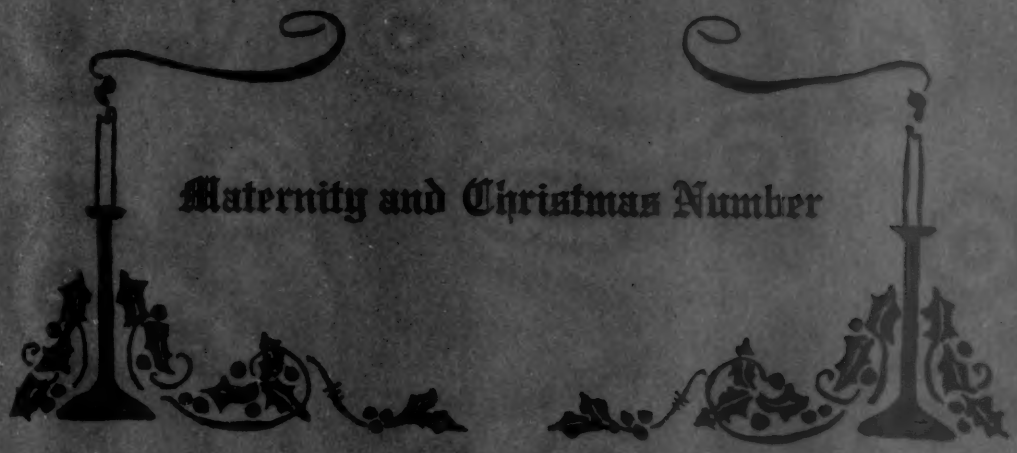
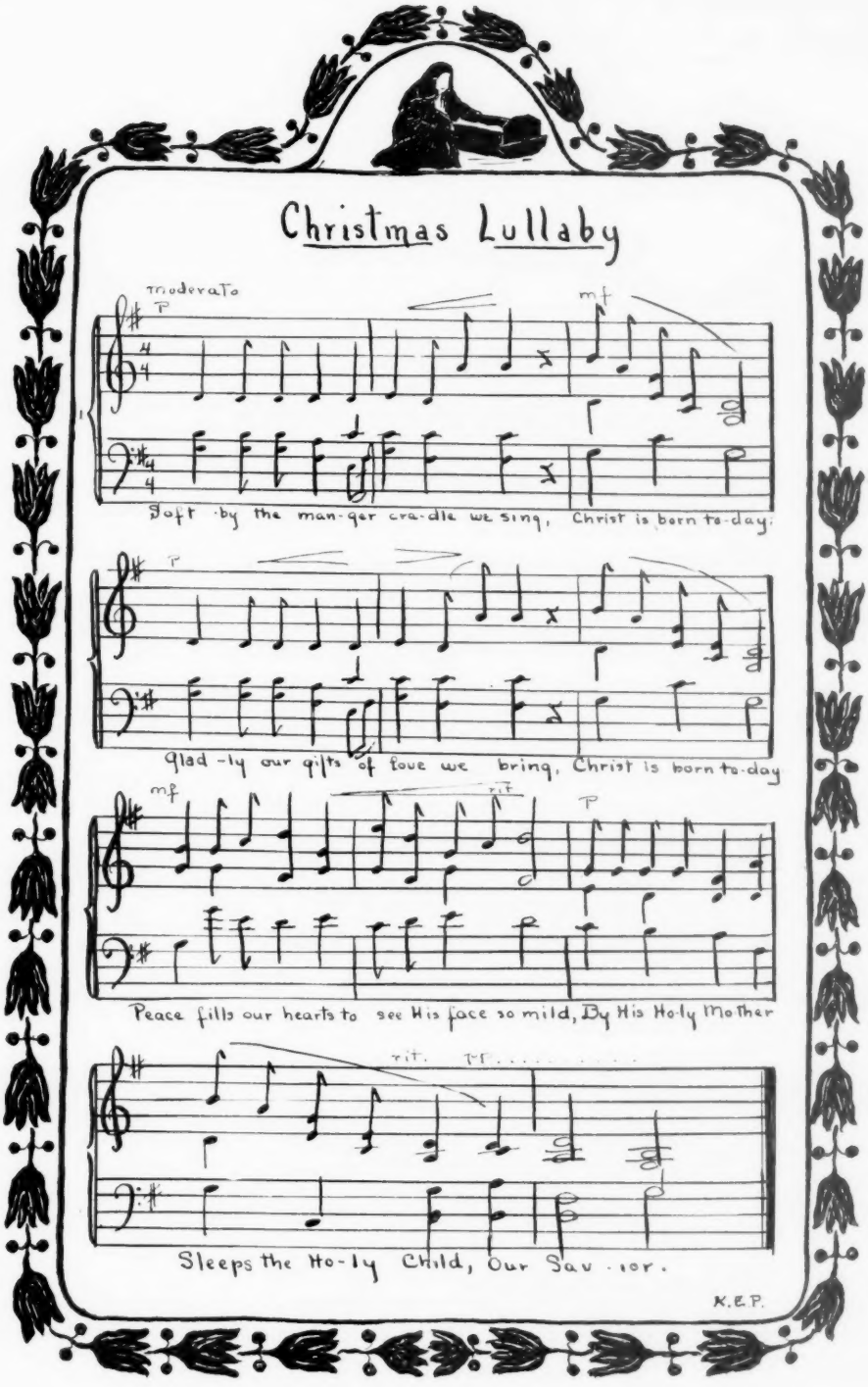




Words, music and illustration by Katharine E. Peirce

The PUBLIC HEALTH NURSE

Official Organ of The National Organization for Public Health Nursing, Inc.

Volume XX DECEMBER, 1928 Number 12

Accomplishments and A Challenge

By Grace Abbott

Chief, Children's Bureau, U. S. Department of Labor

LOOKING back over more than six years of coöperation with the States in the effort to render life safer for American babies and their mothers, we see certain very definite accomplishments that can be entered on the balance sheet. Dr. Haines has summarized them in her 1927 report as director of the Maternity and Infant-Hygiene Division of the Children's Bureau. Readers of THE PUBLIC HEALTH NURSE will, I hope, be familiar with this report, if for no other reason than because public health nurses played so large a part in the making of the history which it records.

The request that has come to me is that I should write, in the light of this past accomplishment, of the work that is still to be done by the nurse, as her part in promoting maternal hygiene in the United States. To do this I must summarize very briefly a few facts which will indicate the line on which we can be said to have consolidated our 1927 gains. With the publication by the United States Bureau of the Census of the infant death rate for 1927 we learned that a new low record had been established which, figured in terms of living babies, meant that in 1927, 24,500 babies survived their first year of life who would have died had the conditions of 1921 prevailed. This is cause for great rejoicing, but in our rejoicing we should not forget that more than 138,000 babies died last year, and with our present knowledge more widely disseminated probably at least one-half of those deaths could have been prevented.

An analysis of the causes of death among American babies shows that in the expanding United States birth-registration area since 1920 the rates for respiratory diseases and epidemic and communicable conditions have shown considerable variation but neither an upward nor a downward trend. There has, however, been a marked decrease in mortality rates for gastro-intestinal conditions, and a slight decrease in rates for natal and prenatal causes. The average annual rate of decrease from 1920 to 1926 in mortality due to gastro-intestinal conditions was 6.9 per cent, while for natal and prenatal causes during this period the average annual decline has been only 1.2 per cent. A study of the activities of the states would lead one to expect this showing. In the future we shall have to emphasize further the fact that better maternal care is necessary to save the lives of both babies and mothers.

But reduction of death rates is not an adequate measure of the value of parental education in the scientific care of children. Children are not only kept alive, but they are in far better physical and mental health as a result of the supervision given by the doctor and nurse at the child health center. The best measure of what will prove of the greatest value to children is the extent to which practical individualized education in child care is being made available to all parents. With this as a measuring rod, progress can be reported. Each year some of the demonstration centers started with state and federal funds have become permanent locally supported centers—in 1928 a total of 310. Each year some counties have been added to the list of those which have undertaken to provide a county-wide maternity and infancy

service. But the expansion is necessarily slow. As yet only 162 out of 2,948 counties in the coöperating states are on this list.

In Behalf of the Mother

What has been done for the mothers? It is too much to expect that the death rate among women in childbirth will show so general and substantial a reduction as does the infant death rate. We begin with a much lower rate for one thing, and it is more difficult to interest mothers in their own health than in the health of their babies. The relation of her health to the health of the baby that is to come, is the appeal that most frequently succeeds with the mother.

Have we made any gains? In 1927 the maternal death rate, *i.e.*, deaths per 10,000 live births, was 64.7 as compared with 65.6 in 1926. Of the 35 states in the birth-registration area in 1926 and 1927, 19 reduced their rates, the rates in 2 remained practically stationary, while in 14 states the rate was higher than in 1926. The expanding birth-registration area makes any conclusions difficult as to the general maternal-mortality trend. The 16 coöperating states which were in the birth-registration area from 1917 to 1926 all show a decrease in the rates for the periods 1922–1926 as compared with 1917–1921 (the year 1918 being omitted because of its abnormally high rate).*

In the states showing the largest reduction in the death rates special activities were undertaken in addition to general education as to what constitutes adequate prenatal and confinement care, which was carried on in all the coöperating states. A majority of the states showed greater reductions in the rural than in the urban area, state efforts under the maternity and infancy act having been directed especially to the rural problem.

There is no single cause of the high maternal death rate. Isolation, untrained midwives, lack of appreciation of the importance of prenatal supervision and consequent failure on the part of many women to consult their physician during the early part of pregnancy, inadequate hospital facilities in many rural sections, and poor technique in some hospitals are among the causes.

With a plan worked out by the Bureau's Obstetrical Advisory Committee, a maternal-mortality study, undertaken at the request of the state health officers and the state medical societies, is now under way in 15 states.**

An investigation along similar lines has been planned by a committee appointed by the Minister of Health in Great Britain, where the maternal mortality rate is also high, although lower than in the United States. We shall have as a result of these studies—for the English one will undoubtedly be useful to us also—much better information on which a program of work can be laid out than we now have.

Educational Work

The educational work that has been done through prenatal letters, home visits of nurses, maternity consultation centers, lectures, etc., has laid a foundation of interest and community cooperation for the prevention of these most tragic of all deaths. The Maternity Center Association of New York has pointed out in a report on the Maternity and Infancy Act in Operation that we "can not have adequate care for every mother until we teach the mothers and fathers what adequate maternity care is and why it is necessary." It is this which we must look to the nurse to do. For whatever plan of organization is adopted, or whatever agencies assist in meeting the cost it entails, the public health nurse will be relied upon to serve as the teacher and expounder of the new mode of life

* Children's Bureau, Publication No. 186, p. 39. *The Promotion of the Welfare and Hygiene of Maternity and Infancy.*

** Alabama, California, Kentucky, Maryland, Michigan, Minnesota, Nebraska, New Hampshire, North Dakota, Oklahoma, Oregon, Rhode Island, Virginia, Washington, and Wisconsin.

which approaching motherhood renders necessary. How much the individual nurse will be able to accomplish will be determined by how well her program of activities is worked out for her, upon the medical and nursing supervision she has, and, finally, upon her own training, judgment, and understanding.

Training and Supervision

One of the problems of the supervisors of the nurses in the maternity and infancy work has been the difficulty they have had in securing trained and experienced nurses for county work. The state directors have endeavored to meet this problem in different ways. The first attempt was to give nurses who had been out of training school for some years the information they needed as to the newer methods of maternity and child care—especially with reference to nutrition and infant feeding, and the routine to be followed in prenatal care. Next, directors sought to make available the experiences of those who had organized successful clubs, classes, and consultation centers for mothers. They began usually with state-wide meetings and institutes for maternity and infancy nurses, held at the time when the state nursing association met. They arranged regional and group conferences on local problems. News letters, loan libraries, and other devices have been used to keep up the professional standard of the nurse who serves the mothers in remote rural areas. Members of the state staffs have given lectures on maternity and infancy work to training schools and classes in public health nursing.

A maternity and infancy nursing demonstration and teaching center was started in Fulton, N. Y., in 1925. While it was primarily for the purpose of training the state nurses for their work, it has been open to other nurses also. In the same year Virginia began a training experiment in coöperation with the Virginia School of Social Work and Public Health Nursing. Some maternity and infancy nurses were sent to the training center at Indianola, Miss., which has increased its training resources to meet this demand. Nurses trained at the Maternity Center Association in New York have been much in demand not only because of their fine technical equipment but because of the missionary spirit they brought to the work for mothers.

Some of the states unable to get nurses who had any public health training or experience planned from the beginning to initiate the inexperienced nurse carefully into the local work. The work in South Carolina was described at our fourth annual conference of state directors as a necessary compromise with the standards which the National Organization for Public Health Nursing recommended.

But this is not enough. Every maternity and infancy nurse must be a teacher of maternal and infant hygiene in the homes, at the centers, and in clubs and classes. She must be able to make plans and secure community cooperation in carrying them out. The opportunities for training for this work should be more general before states and counties can demand a standard of experience which successful work requires. The trial-and-error method by which the untrained nurse gets her experience is far too costly.

In the report of the committee to formulate standards for positions in public health nursing which represented the Conference of State and Provincial Health Authorities, the American Public Health Association, and the National Organization for Public Health Nursing, I find constantly repeated that in addition to the services required in the fundamental, technical education, theoretical instruction and practical experience in one or more of the following services is recommended: "Public health nursing, communicable disease nursing, tuberculosis nursing, hospital social service, and mental hygiene." There is no mention of special training for the "promotion of the welfare and

hygiene of maternity and infancy," to use the language of the Sheppard-Towner Act. While the fundamental education of the nurse includes training in pediatrics and obstetrics she needs training and experience in how to organize and carry on a preventive program in this field or much time will be lost and unnecessary opposition to the program provoked.

One of the important results of the last six years of work in the states, Dr. Haines has pointed out, is that with few or no trained workers outside the large urban centers in 1922 we now have an experienced group who have gained practical training in the field. Progress has also been made in the planning and supervision of the nursing activities. The well-trained nurse seeks the help and encouragement in working out local problems which the state medical director and the state supervising nurse can give. The inexperienced nurse, while less conscious of her needs, is to that extent in greater need of help. In many counties the nurse has a generalized program and gives only part time to parental education, and the local health officer, if there is one, is often personally responsible for carrying out the whole public health program of the county. Both need the assistance of medical and nursing specialists in maternal and infant hygiene if the money expended is to buy the health for mothers and babies which it can be made to buy.

"Carrying On"

All of this, I am aware, will seem very dull to those who desire to discuss the possibilities of the nurse-midwife and other new, not to say revolutionary, suggestions. Some experiments are being made and others will be made in an attempt to meet what is, I hope, the fast disappearing problem of extreme isolation. We are all interested in these experiments. For the country as a whole, the main problem is, however, to extend steadily the urban, rural, and small-town provision for American mothers and to make the nurse as effective as she can be made in the environment in which she must work, while at the same time plans are laid to improve local conditions. And so we come back to the conclusion that what we need is the resources to expand and make permanent activities whose value has been demonstrated, that the quality of the nursing service shall be made the best that can be secured, and that the work be so planned and supervised as to insure the largest measure of success. The nurse's task is only begun, not completed.

The Newton Bill (H.R. 14070) to which we gave notice in our October number makes provision for the continuance on a national scale of the work which has been carried on under the Sheppard-Towner Act which terminates in June, 1929. It provides for federal coöperation with the states in a program of reducing the maternity and infancy death rates. But it does not demand as a requirement for that coöperation that state funds must be appropriated to match the federal grant.

An advisory committee is created to give counsel to the chief of the Children's Bureau. Five non-governmental members may also be appointed—experts in the field of child welfare and child health, one of whom must be a state health officer, appointed from the membership of the Conference of State and Provincial Health Officers.

This measure will be before the Committee on Interstate and Foreign Commerce of the House of Representatives when Congress convenes in December.

Christmas Spirit or Good Technique?

By Virginia Conklin
Staff Nurse, Henry Street Visiting Nurse Service, New York City

AN apartment with a view of the East River may be a social asset, but much depends upon the part of the river. It was not the picture of a charming pent house arrangement that flashed persistently in Dorothy Parker's mind, as she walked to the office on Eleventh Street in her Henry Street Visiting Nurse's uniform, but of two meager little rooms on the brink of Tenth Street where a sullen Italian woman, husband deserted, struggled to rear her daughter by great-grandmother's methods.

When the child was stricken with rheumatic fever the nursing service was welcome enough. As she began to improve the mother was slow to assume the care for she couldn't see that the "fuss" was very important. Even the doctor, who spoke her native language, failed to convince her for she was anxious to get back to her job in the factory. Funds were low and she would be under obligation to no one.

To register Angelina in the cardiac clinic was a tedious task. The doctor advised country care. Angelina's dark eyes brightened. She had heard a lot about the country, like Central Park! But—"She stay home with me, see? Bet your life!"

The doctor advised removal of tonsils—"Whatsa mat? You wanta killa my child!" Mrs. Caponi raged. Angelina clung to her skirts frightened as Mrs. Caponi stormed out of the hospital.

What can a nurse do with a person like that? Reasoning had the weight of a feather on cast iron. It took no special courage, however, for Miss Parker to repeat the doctor's suggestions on occasional visits. Angelina was always happy and proud to see the nurse. "Save a your feet, Miss," said the mother at last, "No use." But Miss Parker could not forget Angelina, pale, appealing little child that she was.

In mid-December, influenza saw fit to visit Mrs. Caponi. She wanted to live; she would not go to a hospital. A neighbor came in and did what she could. Miss Parker was called in to

care for the sick woman. Puzzled by no change in the nurse's manner the patient decided that the smile was part of the regulation uniform. Miss Parker was not the only Henry Street nurse Mrs. Caponi had seen. Come to think of it they were always smiling.

"Gooda girl" she said as the nurse left her refreshed and a little stronger each morning. Finally, she sat up in a chair for the first time, surprised at feeling so weak. Even if she had the money she would not be able to do her Christmas shopping in the attractive push cart section of First Avenue. It was lucky indeed, to have money to pay the current bills with enough left for food until she could return to the factory. The air, even on lower Tenth Street, had a whiff of Christmas in it.

The day before Christmas is always a very busy one at a Henry Street Settlement office. The list of those who are poor, and yet not dependent

on a social agency, is long. These people must not be forgotten, especially the shut-ins and the children. The supply of donated gifts is ample. They pour in all the week.

Miss Parker had made selections for all her families, but had found nothing fitting for little Angelina. The nurses grouped about the long table. Many new gifts had come in the night before. They were piled high. At the end of the table, Miss Parker spied a dark curl sticking out from under a cardboard game box. The competent hands of the nurse from District Five were perilously close. Miss Parker held her breath. The telephone rang!

"That must be Mr. Edwards, calling again, Miss Steves," she said nonchalantly. She lost no time in gaining the place of the unsuspecting one. In a second she had rescued a beautiful doll from a ferocious lion and a regiment of wooden soldiers! She held it up, eyes like Angelina's. She could have hugged it.

"Dorothy still loves dolls." The nurses all laughed at her. That afternoon she visited Mrs. Caponi when the child was in school. For the mother she brought a soft, warm scarf, daintily wrapped and sealed with "Not to be Opened Until Christmas."

"Nice a girl." Mrs. Caponi patted her arm with a fat hand; her illness had made little impression on her bulk. Then she had a peek at the lovely doll with the card "To Angela Mia." "Whata ma gonna do? Too good, too good." The cheerless Christmas she had dreaded was not going to happen.

Two weeks later, stronger and somewhat embarrassed, Mrs. Caponi visited the nurse in her office. "Angelina too skinny. I feeda like you say. Maybe we better take out a da tonsil. Tella da Doc, a please, about da heart. He'll know hisself? Tell a him, be careful please, she's all I got."

Postcard published by Junior Section, Hungarian Red Cross

The Next Steps in Maternity Nursing

By Mary V. Pagaud
Superintendent, Child Welfare Association, New Orleans, La.

WHAT are the next steps for public health nurses in protecting community health? In many localities, the organization of public health nursing has been carried to a point where only more money is required in order to make the service commensurate with the community need. Essentials of technique have been worked out and put into practice. There is no longer any question of "educating the public" to a conscious appreciation of the nurse's value. The demand far exceeds the community's financial ability to meet it. Therefore, nursing agencies are reviewing their records of achievement and analyzing in definite terms the health demands of the community which nursing service alone has not been able to meet.

Every analysis of the maternity field shows an outstanding need for better obstetrical practice. Dr. Lee K. Frankel tells us that between 1918 and 1925 deaths among infants over one month of age declined at the rate of 7.4 per cent per annum, the deaths of infants under one week of age, excluding the first day, declined at the rate of 1.3 per cent per annum, while the mortality of the first day of life declined not at all. He further calls our attention to the sharp increase in the death rate from injuries at birth during the past ten years. Deaths from this cause have increased more than 5 per cent per annum. In 1925 injuries at birth accounted for 14.5 per cent of the deaths on the first day of life and for 16.7 per cent of the deaths during the first week.* When he turns to maternal mortality, Dr. Frankel states that deaths from puerperal sepsis have not declined during the last ten years and accounted for 241 deaths for each hundred thousand births in 1924. A decline in puerperal eclampsia amounted to only 1.7 per cent per annum while accidents of labor have declined only 2 per cent per annum. There is little comfort in these figures or in the fact that the United States with all its medical facilities still ranks seventeenth in the list of seventeen countries in point of view of maternal mortality. Evidently, the reduction of parturient death rates is a primary obligation. Is it not equally evident that if these death rates are to be reduced by public health agencies, physicians as well as nurses, are needed on the staff?

In every community there are women who turn to midwives because they wish to be delivered with privacy in their own homes and are neither able to pay the physician's usual fee for this privilege nor are they willing to be used as teaching material in the outpatient delivery services of hospitals. This group is a large one and will exist as long as there are mothers with limited incomes and growing families. An organized home delivery service that will meet the need of this group and replace the midwife can be arranged through a public health agency that includes both physicians and nurses on its staff. To attempt to meet it through the free or part charity work of the individual physician is unjust to the physician and unwise for the patient.

From the physician's point of view, organization through an agency offers protection from the too frequently repeated calls from charity or part-pay case. Every successful obstetrician has a growing practice that makes unusually heavy demands on his time and vitality. Often he stipulates that his paying patients shall be delivered in an institution, both for their own protection and for the conservation of his own time. He willingly takes a limited number of non-pay patients, but he is

* *Am. Journal of Public Health*, December, 1927, page 1210.

justified in feeling that these should be the abnormal hospitalized cases requiring exceptional skill. The normal non-pay case is usually referred to the younger physicians, well trained in obstetrics, who are now being graduated in gratifying numbers.

But these young physicians cannot afford to serve an unlimited number of cases who pay more frequently in gratitude than in cash. With such physicians, the pay call must usually take precedence—and the non-pay maternity case, requiring long hours of exacting service, receives instead the hurried attention that is the bane of good obstetrics and the *bête noir* of the public health nurse. The need for the young physician is real, but the cost of his services should be underwritten by the community and the type of service required of him should be standardized by the agency that sponsors him—even as nursing service has long been standardized.

An alternative to the medico-nursing staff is the "nurse-midwife," the graduate nurse specially trained in obstetrics and licensed to give complete care to the apparently normal obstetrical case. The nurse midwife may be a substitute in rural areas where good physicians are scarce, but is she needed in cities where good obstetricians are unorganized but not unavailable? The maternity case is always a heavy responsibility. Where well trained medical service is available, should we ask our nurses to assume undue responsibility? Even the apparently normal case often presents emergency abnormalities during delivery — occasions where there is neither time for nor wisdom in sending such patients to a hospital.

The New Orleans Baby Crop

Before the nurse midwife is resorted to in cities as an alternative to the indifferent obstetrics practiced by the overworked or underprivileged physician, why not try the addition of physicians to the staffs of public health nursing associations?

THE NEW ORLEANS EXPERIMENT

In New Orleans this experiment has been under way since 1920. The Child Welfare Association now has an established maternity service in which both physicians and nurses are on salary from that organization. The service is growing steadily and as it grows, the work of the midwife is declining. The Child Welfare Association delivered 6.6 per cent of the white births in 1923

and 12.6 per cent of the total white births in 1927. (Table I.) In 1920 midwives delivered 52.8 per cent of the births in New Orleans; in 1927 only 35.3 per cent of the births were attended by midwives. (Table II.)

TABLE I. WHITE BIRTHS IN NEW ORLEANS ATTENDED BY C. W. A.

	1923	1924	1925	1926	1927
New Orleans	7,150	7,494	6,915	7,124	7,202
C. W. A.	478	568	768	873	911
Percentage	6.6	7.5	11.1	12.2	12.6

TABLE II. BIRTHS IN NEW ORLEANS ATTENDED BY PHYSICIANS AND MIDWIVES

Attendant	1920	1921	1922	1923	1924	1925	1926	1927
Physicians	4,373	4,986	5,118	5,728	6,042	6,202	6,651	6,993
Midwives	4,891	5,100	5,044	4,540	4,828	3,937	3,819	3,818
Totals	9,264	10,086	10,162	10,268	10,870	10,139	10,470	10,811
Midwife Percentage	52.8	50.6	49.6	44.2	44.4	38.8	36.5	35.3

The growth of Child Welfare service has come largely from patient to patient advertising and from the increasing number of "repeaters" who return to be delivered for child after child—as long as the family income remains within the margin permitted Child Welfare patients. During 1927, of the 911 patients delivered, 21 per cent had been previously attended by the Association; 31 per cent were primiparae; 37 per cent were formerly attended by midwives; 6 per cent had been delivered in the charity wards of hospitals; 2 per cent had come into New Orleans from the country to be delivered and 3 per cent had previously had a private physician but were no longer able to pay the cost of this service.

Whether a patient can or can not pay a private physician is not left to the discretion of the patient, the income of every applicant's family is *verified* by letter or telephone call to the man's employer, and this practice, far from alienating the good will of the business man, now has their expressed approval and coöperation. More slowly, but steadily, the medical profession has also realized that through this practice of verifying incomes, the Child Welfare Association has minimized the abuse of this service and is returning to private physicians families who are able to pay even a moderate fee. On the cases returned, the Child Welfare nurses will assist the private physicians. In 1927, 92 physicians were thus assisted on cases. In mute evidence of the growing popularity of the service with physicians is the long list of applicant physicians waiting vacancies on the obstetrical staff of the Child Welfare Association.

The plan by which this service is operated was explained in detail in THE PUBLIC HEALTH NURSE of November, 1923—and while a better technique has been developed, the essentials of the plan have not been modified. The success with which it operates permits us to suggest it as a preferable alternative to nurse-midwives in cities.

For the possible interest of other executives, we append the following list of equipment:

PRENATAL BAG

This bag is the standard Erpenbeck & Segessmann Visiting Nurse bag. The lining is white indian-head—detachable and easily laundered. This lining is stiffly starched but has no clips. It is kept in place by the pockets which form convenient receptacles for the apron and for other articles needed at the beginning of the visit. Smaller bags and wrappers are of white cotton. The bag is always carried in the maternity nurse's car and is used for the prenatal clinic, for the prenatal home visit and to supplement the labor bag.

In white wrappers, 3 rubber gloves—one No. 7 (for nurse) and two No. 8 (for physician)
White indian-head bag cover for syringe case
10 c.c. Luer syringe (1-in. platinum needle) in metal case
2 c.c. Hypo syringe (gold needle) in metal case
Bottle, screw-top, for matches
Alcohol lamp and indian-head bag for alcohol lamp
Blue bottle, screw-top, for acetic acid
Street book carrier containing nursing records
Receipt book
Reference forms

Nurses' call cards
Maternity call cards
Printed labels
6 half paper napkins
10 whole paper napkins
Sphygmomanometer in leather case and indian-head case for sphygmomanometer box
4 glass slides
Stethoscope in white indian-head case
Thermometer in case
Absorbent cotton wrapped in blue paper and indian-head bag for cotton
Bottle, screw-top, for alcohol
Nurse's apron
Bottle, screw-top, for green soap
Nail brush with red rubber case (this brush is to be replaced by the Takamine Nail Brush)
16 paper towels in indian-head case

LABOR BAG

This is a traveling man's fibre cabin bag—economical, light, durable and easily reconditioned. The lining is white indian-head, detachable and easily laundered. This lining is stiffly starched but has no clips. It is kept in place by sections of umbrella ribs inserted in re-enforced corners of lining. Smaller bags and wrappers are made of heavy white cotton marked in red. This bag is used only for deliveries and is carried by the nurse. All maternity nurses have automobiles.

1 needle holder
1 pr. tissue forceps
1 pr. uterine forceps
1 pr. straight Mayo scissors
1 pr. bandage scissors
2 Ales' clamps
Indian-head case for instruments
Scale
2 tubes chromic catgut
4 ampules half c.c. pituitrin
Tin box containing 2 ampules $AgNO_3$ (1%)
White indian-head bag to hold catgut, pituitrin and silver nitrate
Round metal case containing 4 curved Kelly needles and 3 strands silkworm in metal sterilizer
White cotton wrapper containing following sterile supplies:
  1 pr. straight scissors
  2 cord dressings
  2 umbilical clamps
  1 14-in. cord tie
1 medium Graves speculum and white cotton bag for speculum
1 pr. No. 7 sterile gloves in indian-head case
1 pr. No. 8 sterile gloves in indian-head case
White cotton bag to contain:
  2 ampules alpha lobelin
  2 ampules ergotol
  2 ampules camphorated oil
Brown drop bottle
1 safety razor with two blades in case
Ether mask with cotton bag
¼ lb. Chloroform
¼ lb. Ether
Aluminum square pan in linen case
History sheets and cards for physician and nurse
2 White cotton wrappers containing 4 small sterile towels each
White cotton wrapper containing 1 large sterile towel
4 bottles, screw-tops, containing:
  Ergot
  Quinine
  Alcohol
  Lysol
1 douche bag with white cotton case
1 pr. leggings, sterile
1 physician's gown, sterile
5-yd. gauze pack, sterile
1 rubber catheter

IN THE FIFTH CENTURY, B.C.

A whole quarter of Utica where the pottery of the early Phoenicians was made had kilns of rough red brick. In these were found little pottery savings banks with coins still inside, but the most human of all objects were babies' milk bottles. They are small jugs about six inches high, with the top covered, and a tiny little hole, through which the jug is filled. The nipple was part of the jug, shaped to roughly represent a diminutive breast. Sometimes eyes, and a laughing mouth are painted on these pathetic relics.

Excavation has its sad side, even though history may value the additional verification of certain theories. I have discovered similar milk bottles among the sacrificial urns at the Temple of Tanit, in Carthage, and Père Delattre has found them in the tombs of little children in his own excavations there. They date from about the fifth century B.C.

Discoveries near the kiln included a series of grotesques which must have been children's toys. There were conventionalized figures of horses, goats, sheep, cocks, and most of the domestic animals with which we ourselves are familiar.

Digging for Lost African Gods—Byron Khun De Prorok

Round Table On Delivery Service *

COST OF DELIVERY SERVICE

Presented by Marguerite A. Wales, General Director, Henry Street Visiting Nurse Service, New York City

QUESTIONNAIRES as to methods of computing costs of delivery service were sent to several organizations—fourteen replied. From the answers, it is evident that we are each working independently on this problem, and that few of us have reached what seems to be a satisfactory working basis.

Some associations include in their cost figures only the actual deliveries attended; others figure on all calls answered for that service, whether or not the nurse arrived in time to assist at the delivery, or whether it was a false call. The costs as given varied from $2.34 to $12.04 per delivery. In certain associations rental is included as a cost item; in others the nurse takes the calls in her own home. Telephone service also depends on the method of carrying the work. One association has an arrangement with the local doctor's exchange, paying $2.50 a month for telephone service. All but one organization includes transportation.

In many of the associations, the regular staff carries the delivery work. In all but three extra salary of $5.00 to $10.00 a month is paid to the nurse who carries this work. In general, where delivery service is offered, it is community wide. One organization limits their work to paid cases.

As a starting point in this discussion, it might be well to explain the cost method used by the Henry Street Visiting Nurse Service. Formerly the delivery staff was made up largely from a student group of an affiliating maternity hospital. Since March 1, 1928, the service has been carried by a graduate staff, three of whom are on full time as night delivery nurses, and the others chosen from the regular staff in the districts where this special service is offered (a limited area, covering a population of approximately 650,000). The nurses who are taken for this work at night from the regular staff are on call. Those on call five nights a week receive $10.00 in addition to regular monthly salary; those on call three nights a week receive $5.00 in addition to regular monthly salary.

In estimating the cost for March and April, 1928, the following items were included:

The cost of the time of the nurses and supervisors.
An item for light, heat, carfare, laundry, equipment, telephones, depreciation, repairs, stationery, postage, and cleaning.
Clerical service.
An item for executive salaries.

In estimating the amount to allocate to delivery service for executive salaries, heat, light, etc., each delivery call was considered to equal in length of time four general visits. It costs approximately ten cents on each visit for these items. The nursing, supervising and clerical time was time actually spent for delivery work. The cost of all delivery calls was found to be $6.86. Basing costs on number of actual deliveries attended the cost for each was $10.00. The case load averaged 30 cases per nurse per month, the average length of a delivery was four hours, and 29 per cent of the calls came during the day service from 8:30 to 5 P.M. Two hundred and seventy-six of the 331 calls were to patients of an out-patient clinic; the remaining 55 calls brought in $197.00, or an average of $3.56 per call.

In the Providence District Nurse Association, the method of computing cost considered the time spent in the delivery service divided by the time of a regular visit, in order to determine how many regular visits could be made in the delivery time. This number of visits was then multiplied by the cost of the regular visit and the amount thus obtained was divided by the number of deliveries.

Since there is found to be so little uniformity in the method of computing costs for delivery service among the organizations, it

* N.O.P.H.N. Biennial Convention, Louisville, Kentucky, June 5, 1928.

is suggested that after discussion, this group consider either the appointment of a committee to consider the items to be estimated in delivery costs; or the reference of the suggestions from this meeting to the Service Evaluation Committee of the National Organization for Public Health Nursing for study and recommendation.*

*Discussion by Winifred L. Fitzpatrick, Associate Director, Providence District Nursing Association, Providence, R. I.***

PUBLICITY

Eva C. Smith, Supervisor, Visiting Nurse Association, Hartford, Conn.

During the past year, the Visiting Nurse Association of Hartford has had a rather phenomenal record, with an increase in work of 17 per cent and a reduction of ten cents in the cost per visit.

One of the outstanding reasons for these results is the publicity given in the daily newspapers each week. The maternity service has not been definitely featured, but has shared in the publicity given the whole program.

Our service is generalized and we feel that the continual search for expectant mothers, and prenatal instruction by the field nurses have meant a great deal of publicity for the service. Our association has a printed calling card, giving a summary of the services we carry, the obstetrical service, of course, receiving its share of explanation.

In introducing mothers' classes, cards were printed for distribution by the nurses in the homes. On these cards we asked, "Do you know: What supplies to provide for your coming baby? What care to give yourself? About a nurse for home confinement? The easiest way to care for baby after he is here?" We then announced the mothers' clubs, where this information could be obtained. However, we found that the mothers could not give time to both baby health conferences and prenatal classes so we turned our attention to the mothers who were attending the prenatal clinics at the Hartford Dispensary and the Hartford Hospital. Here a nurse attended and met the mothers, exhibiting the baby basket, tray and clothes, as well as the mother's outfit and supplies, with a miniature bed prepared for delivery.

Discussion by Mary V. Pagaud, Superintendent of Nurses, Child Welfare Association, New Orleans, La.

Editor's Note: So many of Miss Pagaud's points were covered in her discussion on publicity at the luncheon for executive directors, that we are referring our readers to the report of this luncheon (THE PUBLIC HEALTH NURSE, July, 1928, page 386). Also for a description of the New Orleans delivery service, see page 622 of this issue.

DELIVERY SERVICE IN A SMALL ORGANIZATION

Ruth Morton, Assistant Director, Instructive Visiting Nurse Association, Richmond, Virginia

For some time the executive director and nursing committee of the Instructive Visiting Nurse Association felt that they had a weak link in a maternity program that gave a prenatal and postpartum service, but deserted the mother at her most critical time. Lack of funds was the not unusual reason for delay in establishing such a service, but in 1924 it was decided to offer a limited service that might in time grow to be both adequate and satisfactory.

The Medical Advisory Committee appointed by the Academy of Medicine, after a survey and consultation, approved the plan, and letters were sent to members of the medical profession for their approval, suggestions or modification.

In the approved plan—

All cases were to be registered with the Instructive Visiting Nurse Association for prenatal instructions.
The nurse was to remain only as long as the doctor was in the home.
A fee of $5.00 was to be charged those able to pay.
A taxi was to be used at night, the family to pay this fee if able.

* The Service Evaluation Committee has the suggestion under advisement.
** For a description of the Providence delivery service, see THE PUBLIC HEALTH NURSE, June, 1928, page 294.

The majority of the Richmond physicians approved the plan. In October, 1924, the service was instituted. Two nurses were added to the staff, and we launched it by using one of our supervisors as the first call nurse, and two of our older nurses, who volunteered, as second and third call nurse respectively at night.

During the first month 45 cases were registered, and seven deliveries were attended.

Each nurse attends the deliveries in her own district during the day. Three nurses are on night call together as first, second and third call nurses for one month; they arrange a weekly schedule of time to suit themselves, sending a duplicate schedule to the doctors' exchange, where a duplicate card file is kept, and night calls relayed to the nurses on the service. A rest of two months is given before the same group of nurses is again subject to call. The nurse on first call receives $10.00 extra salary per month, the second and third call nurses receive each $5.00 extra.

Because our cases are all registered, and have prenatal supervision, we carry no extra bag equipment except for the addition of haemostats, eyedrops, cord ties and cord dressings.

We answer real emergency calls on non-registered and non-carried prenatal cases. We charge $5.00 per delivery regardless of time spent, but will register for part of the fee or free of charge any case which the nurse and doctor recommend. The delivery service is offered only to white patients, and we have a small staff of twelve white nurses, who carry our generalized service, and also the night deliveries as outlined. We do not watch cases for the doctors.

In 1927 we attended 157 deliveries with an average time spent of 2 hours and 56 minutes. We feel the service is inadequate in an organization carrying 200 prenatal cases per month, making 6,684 prenatal visits and caring for 1,232 new born babies in 1927. We are hoping to expand—but how and where are the problems.

Discussion, Gertrude H. Bowling, Director, Instructive Visiting Nurse Society, Washington, D. C.

The present plan of administering a delivery service has been in use for about three years in Washington, D. C. It serves a population of 500,000 in an area of 69 square miles. Each nurse agrees when she is accepted on the staff to serve her turn in the delivery service. This assignment is never made more frequently than once in twelve months and with the present size of the staff, the interval is often from fifteen to eighteen months between assignments.

Three nurses are always on duty as delivery nurses for two months, and take turns on first call night service. During the day, unless they have been out the night before, they do generalized work in their regular districts. Time spent on night service even for one case is made up by giving the nurse the full day off duty next day. The second and third call nurses alternate on night call. The exact time spent on delivery is made up to them the following day. The nurses assigned to this service receive an increase of $15.00 per month on their basic salary.

The question naturally arises as to what happens to the nurse's district when she works at night and is not on duty the following day. At present, this is taken care of by substitute work from the other districts. A plan, tried out with some success, included, in addition to the three regular nurses on delivery, a nurse who was known as a delivery "floater." This nurse was automatically assigned to the district of the delivery nurse when she was absent because of night work. This plan was given up for two reasons: first, the service was a small one, averaging only about thirty cases a month including day and night deliveries, and second, it was most difficult to keep properly qualified nurses on the staff as "floaters" or substitute nurses.

The night calls are handled by a registrar who has a private registry to whom the organization pays $25.75 per month. The nurses on first and second day call telephone in to the office every hour during the day. The first call night nurse telephones to the office at 4:30 in the afternoon in order that she may relieve a day nurse if she is on a long case.

The charge for the service is a flat rate of $5.00 and the cost of a taxi when necessary. Care is also given to part pay and free patients. No extra charge is made for prolonged service in the home or for false calls. The average time spent on delivery is about

four hours. Emergency cases are not taken except at the personal request of the physician to whom it is explained that the call is answered only as an emergency. The nurse does not watch labor for the physician.

The delivery nurses have a long week end from Saturday noon until Monday morning every third week. The second and third call nurses have an afternoon and evening off duty each week from 12:30 P.M. until the following morning. The nurses rotate and are on first call for a week at a time.

We attend about 400 deliveries a year, exclusive of false calls. There are about 400 midwife deliveries and approximately 250 deliveries by the out-patient delivery service. Sixty per cent of all patients are delivered in the hospitals.

CONCLUSIONS

Hazel Corbin, General Director, Maternity Center Association, New York City

The aims of adequate maternity care are to secure for every mother the minimum of mental and physical discomfort throughout pregnancy, the maximum of mental and physical fitness at its termination, with the reward of a well baby and the knowledge whereby mother and baby may be kept well.

Adequate maternity care includes medical and nursing supervision, instruction and care continuously from the beginning of pregnancy until the baby is at least six weeks old and is under the care of a pediatrician or health station, and the mother has had a post-partum examination and is found to be in condition to resume her usual activities and added responsibilities, or until any indicated treatment has been arranged for.

In considering the value of a delivery service, as one phase of complete maternity care, it may be well to have in mind that from the few reports which are available the mortality rates for both mothers and infants are better where complete service has been given than they are where delivery service or either one of the other two services have been omitted. The value of one phase of the service is dependent on the thoroughness with which the other two services are rendered. If, because of cost, and it has been so suggested, we must decrease any one phase of adequate maternity care, would it not be well to consider decreasing the amount of post-partum practical service which we give and put more emphasis on teaching during the prenatal period and on giving adequate delivery service?

An adequate delivery service should provide nursing care from the onset of labor until after the baby is born and both mother and baby given necessary care. The nurse should stay if the doctor goes. If doctors can not or will not stay with mothers during labor, all the more reason for a nursing service. If we consider the reason for a nursing service at confinement, I do not see how we can decide to discontinue nursing service when the doctor goes. Normally the new mother is not ill after delivery. Anyone can give her the practical care she needs provided there is skilled supervision. After all, *anyone* does give the mother who is cared for by a visiting nurse association practical care approximately twenty-three hours out of twenty-four; the visiting nurse gives care only during one hour. Would not the mother be assured of a more uniform and higher standard of care if the nurse spent more time teaching the neighbor or friend or working housekeeper how to give care under her direct supervision that she might learn while giving the care? This should, at the same time, not only secure for the normal post-partum mother a better standard of care but should release nursing time so that the mother who has complications and needs more skilled nursing for a longer period may have it. If we assume responsibility for nursing a mother during the post-partum period we should be prepared to give whatever nursing care is necessary, whether it be on the basis of visiting nursing, hourly nursing or constant care.

Emphasizing this point, we need very well trained, skilled nurses to give post-partum *supervision* to all mothers, and *care* where there is any abnormality, but the visiting nurse service would be more nearly meeting the need which it does not now meet, if the nurse spent more time teaching someone else to do, intelligently, what must be done when the nurse is not there.

Juniors in International Health Education

By Charlotte F. Kett
Junior Red Cross Division, League of Red Cross Societies, Paris

"WHAT a futile effort!" scoffed the critic, as he cast his eye over the "Health Game Chart" in the hand—the fairly clean hand, be it noted—of nine-year-old Mariekie in her ragged sheepskin jacket in the bare schoolroom in the middle of Macedonia. "'I slept ten hours with the windows open'—how on earth can any child in this part of the world accomplish that? Not a parent would permit it. First of all it's too bitterly cold in winter, there are too many mosquitoes in summer, and anyway you've no inkling of the psychology of the people of this part of the world if you fancy anyone is going to tempt thieves in so foolhardy a fashion."

"I Serve"
Postcard published by Junior Section, Hungarian Red Cross

"As for the cold," I gently rejoined, "you forget perhaps that extra bedding can be added—and that whatever else is lacking, wool is plentiful hereabouts. Of course, mosquitoes are more plentiful still—but such things as mosquito nets *do* exist. And as for thieves, they are as a matter of fact far less prevalent than the fear of them."

"The fear persists all the same, and it will take centuries of peace such as the Balkans have never known for it to be overcome. Come, confess, not a child in Macedonia has ever checked in this space—not honestly, at least—has he?"

"One did!"

"Regularly?"

"No; only once. His grandfather came home late too drunk to notice the window he had opened."

"There! You see!" The critic gloated, "What on earth do you expect to gain with your health program in the face of conditions like these?"

"Not a lot today," I admitted, "but twenty years from now Mariekie's small daughter will be coming home from school with *her* health-game chart. Mariekie's mind will have been prepared, she will remember her own childish chagrin at being unable to put crosses in that column, and it is not impossible that she may conspire with her child to the end that the new generation may succeed where her own could not."

Not all of the factors which condition health are so completely controlled by tradition as are the windows of Balkan villages, neither are all parents so adamant in their opposition to "new-fangled notions" which the children pick up at school. For children *are* picking up the new theories, and while it is not easy to measure their influence, it is wholesome to try, and to decide at what points child coöperation in health work can be improved.

How They Serve

Making a study of the health activities of ten million children scattered in

thirty-three countries, speaking twenty different languages, is no easy task. The existence of a central bureau of information in Paris to which reports are sent by each Red Cross Society belonging to the League of Red Cross Societies offers at least a clearing house for salient facts concerning Junior Red Cross participation in health activities. From an analysis of the reports available at this world headquarters, we find that children on different parts of the earth's surface are aiding in "the promotion of health and the prevention of disease" in some very specific ways, such as:

Raising money for founding, maintaining or aiding children's hospitals, convalescent homes, dispensaries, baby and child welfare centers, health camps and play-grounds.

Establishing special funds, such as:
- Crippled Children's Fund (Canada)
- Milk Fund (Sydney, Australia)
- Eyeglass Fund (New York City)
- Social Service Funds for aid of handicapped children.

Paying for equipment as an aid in healthy living, such as:
- Bathing and washing facilities
- Tooth brushes
- Hot breakfasts and lunches
- Pure drinking water
- First aid cabinets
- School barber-shops
- Dry footwear
- Cleaning equipment (including vacuum cleaners)

Offering personal service in assisting the visiting nurse in little ways; in cleaning and ventilating school-rooms; in helping at playgrounds and health camps; in advertising health; in supporting special health campaigns of all sorts and participating in health parades, exhibitions and the like.

The whole list (not given here) is imposing and represents all the known types of child-participation in health work in thirty-three different countries where the Junior Red Cross is organized and at work. The children of Czechoslovakia have undertaken the greatest variety of health activities. Her neighbor—Hungary—runs her a close second. Canada and the United States follow. In Canada, for example, the Junior Red Cross Crippled Children's Fund has been the means of effecting over 6,200 corrections since 1919. Next on the record of achievement stands Yugoslavia, and then Greece, where the Junior Red Cross is less than four years old. This remarkable development in Greece may be attributed to the fact that the Junior Red Cross has been warmly sponsored by the school hygiene section of the ministry of health.

The Qualities of Interest

In a Junior Red Cross Health program it is not only the physical factors of life which concern us; it is equally health in its ancient meaning of "wholeness." Alongside of the work accomplished by children for the improvement of their own physical health and that of others we must put the effect of the *doing* of that work on the minds, hearts and habits of the children themselves. If they are merely exploited by adult enthusiasts, if their susceptibility to emulation or shame is played upon in order to produce the pennies to operate some undertaking, no matter how worthy, of which they scarcely understand the nature, a moral offense has been committed against them. This is their apprenticeship to social activity. Unless it serves to broaden their interests, to increase their understanding of how such things are done, to deepen their sympathies, to develop their skills and give them experience which will help to shape their characters, the effort has not, socially, paid its way.

Loyalties

The development of a sense of loyalty, indeed a group of loyalties, is the foundation of this health education. We find loyalty to persons, loyalty to the group and finally, loyalty to a "mere idea." Personal loyalty is the strongest, if not the only, motive force among the very young. It may be toward a member of the child's own family, his teacher, the school nurse or a combination of them all. The health habits of those persons who occupy, even temporarily, the pedestal of the ideal in the child's mind count enormously—neatness of clothes, brightness of eye, the glow of the skin have

their subtle effect, just as the habits of exercise and the food selected by their models have more obvious influence.

It becomes important, then, to create a sound public opinion on health questions among the school population, and to identify the right health attitudes so closely with the group that loyalty to the group implies loyalty to those attitudes. It is by no means easy to transfer group loyalty to its final apotheosis, loyalty to an idea or ideal. Children intuitively sense this process. As evidence that this loyalty to an ideal can begin to take shape (in the consciousness of at least the gifted child) at an earlier age than is commonly supposed is nine-year-old Edythe's remonstrance with her grandmother in a phrase which cannot quite be translated because we have no English word which gives the finer shades of meaning of "digne." "Grand'mere," said Edythe in deep concern on going to waken the old lady one cold morning, "vous n'etes pas *digne* de la Croix-Rouge de la Jeunesse—*vous ne dormez pas les fenêtres ouvertes.*" ("Grandma, you are not worthy of the Junior Red Cross, you did not sleep with your windows open.")

Another instance comes from a school medical inspector in Toronto, where every child is taught the rules of health, where a whole city coöperates to keep the school population well and fit, but where, nevertheless, the stout heart of one ten-year-old resisted the entire onslaught of the adult organization. He would do none of the things which were expected of him and above all he would *not* keep clean. His home was investigated. There was no economic handicap. The matter rested with Jimmy. Then Jimmy's class enrolled as a unit of the Junior Red Cross, and Jimmy's teacher may have tactfully suggested that he be made "Convener of the Cleanliness Committee." Jimmy was too young to perceive any possibility of guile in this. Personal responsibility for an ideal took possession of him—and pride perhaps. He became a changed person, a model of cleanliness and a follower of the health rules of the Junior Red Cross. A teacher crystallized the whole aim of this health movement through the Junior Red Cross when she said "not only do they talk health—they live it."

"INSIDE MY CROOKED HOUSE"

My picture's beautiful,
But not complete;
A house, a tree, a moon
Upon the sheet;

The crooked house is red,
The tree is green,
The sky's the darkest blue
I've ever seen;

The house has little squares
For windows bright,
With yellow coloring
To make it night;

The moon is yellow too,
For further proof,
And there are yellow stars
Above the roof.

I want a child behind
A window bright,
Inside my crooked house,
Watching the night—

My head is in my hand,
I keep it there:
How can I draw a child
Inside a square?

Songs of Infancy and Other Poems.
Mary Britton Miller—The Macmillan Co.

The Diet of Cardiac Patients

By Louise O. Canham
Instructor in Nutrition, School of Nursing, Yale University, New Haven, Conn.

Second in a series of articles on special diets—See The Public Health Nurse, *November, 1928*

THIS is a topic which would lend itself to infinite magnitude and detail, but I shall mention only a few of the more important aspects of the dietary treatment of the cardiac patient.

For all heart cases, regardless of diagnosis, age, or complicating diseases, the paramount issue is developing the optimal nutritional state; that means, building up the underweight, reducing obese patients, relieving constipation, and preventing anemia, and yet making digestion and other body functions operate with the minimum effort and strain for the heart. This is no small or easy task and often demands the utmost skill and ingenuity from the person planning the diet. Very frequently renal diseases complicate the problem, and in those cases, the most serious condition must have the primary consideration.

THE UNDERWEIGHT PATIENT

Let us consider first the underweight patient and his needs. We often find young people or children in this class who have grown rapidly in a very short time; there being a disproportion between the circulating organs and the more rapidly developing bones and muscles with the resulting heart which is not up to the ordinary strain of daily life or a slight increase in activities; or it may be a cardiac damage following such conditions as diphtheria, rheumatic fever, chorea, or repeated attacks of tonsilitis. The dietary regulation is the same as for malnutrition, and includes food which is simple, nourishing, and easily digestible, with the exclusion of all fancy dishes without particular nutritious value.

In congestive heart failure, diet may be of extreme importance by virtue of its possible adverse mechanical effects, giving rise to dangerous or even fatal symptoms by pressure on the heart from the bulk of food or from fermentation of the wrong kind of food, or undue distention because of gastric atony. Indigestion in all its forms must be prevented in all cardiac patients. Large meals should be forbidden, likewise gas forming foods such as cucumbers, corn, raw onions, cabbage, turnips, baked beans, rich pastries (mince pie, plum puddings) very sweet foods, and highly spiced or seasoned dishes. Constipation should be prevented by including whole grain cereals or bread, green vegetables and fruits in the diet and drinking 6 to 8 glasses of water daily (unless marked edema is present).

The patient may be underweight either because he does not receive sufficient or the right kind of food due to poor appetite; or because he is not able to utilize it because of disturbed function of the gastro intestinal tract. Small easily digested meals with sufficient bulk to prevent constipation should result in an improved digestion with a consequent gain in weight.

APPETIZERS

For those with poor appetites, I would suggest that the meal be made as attractive as possible by serving well cooked and seasoned food as neatly and daintily as possible. The patient's tastes and dislikes should be considered as far as is compatible with the indications for the diet. The element of surprise often works wonders, particularly with children. Sandwiches cut in fancy shapes, salads arranged to resemble some familiar object, log cabins made of toast strips, fruit jelly or the prosaic rice pudding molded in odd shapes, and the much disliked spinach or carrots prepared in some new way or served in an attractive dish, are all ways of tempting the child's appetite. The patient's interest and coöperation

in gaining weight should be secured. Often a poster calendar with stars for the clean plate days and a suitable reward each week or month will stimulate the youngster's curiosity and interest in eating. Often smaller meals with intermediate nourishments and more rest and quiet, particularly before meals is the most effective cure for a capricious appetite in adults as well as children.

If the patient is both anemic and underweight, the diet should include a green vegetable daily, liver or kidney at least three or four times a week (or daily is even better if the patient will take it), beef or lamb every day and an egg and fresh fruit daily. Liver extract, which is now available, is an easy way of taking a concentrated amount of liver and has been very effective in the treatment of anemia.

A sample menu for an underweight patient follows:

Breakfast:
- Well cooked cereal with cream or top milk
- Fruit (if the patient's digestion is poor use only stewed fruits and orange or grapefruit)
- Toast with butter
- Soft cooked or poached egg
- Cup of cocoa or warm milk to drink *

Mid-Morning:
- Fresh fruit or glass of milk

Dinner:
- Baked, mashed, creamed, or boiled potato
- Creamed chicken or fish, or small portion of broiled steak, chop, liver, or roast beef or lamb (no pork)*
- Bread and butter
- Cooked vegetable such as carrots, peas, asparagus, string beans, etc.
- Simple milk pudding such as rice, tapioca, custard, chocolate, etc.

Supper:
- Cream vegetable soup or cup of cocoa or milk
- Toast or bread and butter
- Baked potato, or creamed macaroni or some other hot vegetable dish if desired
- Cooked fruit or a simple pudding

Bedtime:
- Glass of warm milk

Very often patients with a tendency to arteriosclerosis are obese and a reduction in weight will often result in reduced blood pressure, less dyspnea, and increased vitality and energy. For such people, a rapid loss in weight is not desirable and may even be dangerous. By a conservative limiting of fats, starches, and sugars, a gradual and continuous loss of weight may be accomplished without discomfort or any untoward symptoms. The following diet might be used for such cases:

Breakfast:
- Fresh fruit
- Cereal with milk and no sugar, or
- 1 piece of toast with very little butter
- Egg prepared any way but fried
- Kaffee Hag with milk or a cup of cocoa made with skim milk and the minimum of sugar *

Dinner:
- Broiled chop, steak, liver, or small portion of roast beef, lamb or chicken, or broiled or baked fish *
- Cooked vegetable other than potatoes (those that are gas forming should be omitted from the diet)
- Simple salad such as lettuce, celery, etc. Omit mayonnaise or oil dressings
- Dessert—fresh or stewed fruit without sugar

Supper:
- Cream vegetable soup made of milk and pureed vegetable
- 1 slice of bread or toast with very little butter
- Simple salad or cooked vegetable might be used if the patient has a good appetite
- Fresh or stewed fruit or a simple pudding made with the minimum of sugar
- Poached or soft cooked egg, cream or cottage cheese might be added to the diet if desired.

Often a moderate restriction of fluids is necessary to prevent overfilling of the vascular system, or edema may make the restriction of salt and fluids imperative. The meals should contain the minimum of fluid foods and the liquids allowed should be given in the form of water or the favorite beverage of the patient. If all the foods are cooked to develop the greatest possible flavor, the absence of salt may not be so noticeable. Patients with congestive heart failure and edema often do well on a Karrell diet which consists of 200 c.c. of milk given at four-hour intervals four times a day. No other fluids are used. After a week of this milk diet, eggs and toast may be added and a gradual return to a normal diet

* The sample menus outlined above presuppose that no renal condition or edema is present.

is made. Such a diet is markedly deficient in calories and should be used for only short periods of time. There have been various modifications of this diet suggested, using lactose, cream, and cereals, to increase the caloric value of the diet, but still keeping the fluid intake low.

CHRISTMAS GIVING

"What shall I do? What shall I do?"
So wailed the P.H. nurse.
"I cannot find, I cannot find,
A gift to fit my purse.

"I've searched the stores, yes, all the stores,
And still I have not found
A gift of worth and dignity
To last the whole year 'round."

This card reproduced in colors will accompany each Christmas gift subscription

Then suddenly and joyfully,
She spied this simple rhyme—
"Oh that's the thing, the magazine!
I hope my check's in time."

Her friend was pleased, Oh very pleased
With one whole year's subscription.
This magazine as a Christmas gift—
It beggars all description!

We have a list of interested nurses in foreign countries who will not see the magazine unless we make it possible for them. The Christmas season would surely be appropriate for such an expression of international good will. Have all your friends the pleasure of receiving the magazine each month? If so, why not arrange to extend your Christmas giving to include one or more foreign nurses? The name of the nurse selected to receive your gift will be sent to you if you wish.

Yearly subscription, if sent to non-members of the N.O.P.H.N., $3.00; to members, $2.00. Canadian and foreign postage, 50 cents extra.

The Premature Infant

The rearing of premature infants needs, above all, faith in the possibility of success. The initial fall of temperature at birth is the first factor which threatens our success and must be actively combated. In the British Hospital for Mothers and Babies, Woolwich, England, M. M. Cashmore, certified midwife, has had astonishing success in the care of premature babies. We consider it a privilege to abstract the important points in her method. (*National Health*, September, 1928.)

A warmed bed is prepared beforehand, local temperature about 80 F. not lower than 75 F. at first. The babe is wrapped at once in a warmed blanket, weighed (the blanket being weighed beforehand), mouth and nose freed from mucus and placed at once in the warm bed. No further effort is made to complete the toilet for a considerable length of time, then only the minimum undertaken: the cord is dressed, the infant oiled, and dressed in a loosely knitted coat, diaper with cotton next the body, a blanket and cap are added. No fastenings are used and the wrapping arranged so it can be folded back and the whole body seen at a glance.

POINTS OF SPECIAL NOTICE

Points to notice specially are:

Its general appearance, cry, color, weight, age, temperature and length. A fat premature is not promising, neither is a pretty one. The infant that promises well is ugly, red, thin and energetic. If it spontaneously passes meconium this is a good sign. Absence of effort to cry is more favorable than a little grunty, moaning cry with each breath. The weight is not of such great importance in prognosis as the general condition: a 5 lb. child may present a hopeless problem, while a 3 lb. may promise well.

Nothing gives a clearer indication as to the well-being of the child than the state of the temperature, far more so at first than the state of weight, though this also becomes important later. It is often asked how soon the extra external heat can be discontinued. It should be given up as soon as ever the child can keep up its temperature without it. The time may be long or short, but it will be surprisingly short if the child can take one-fifth of its body weight in human milk and does not exceed that.

The feedings should not be given oftener than 3-hourly, and as soon as possible should be changed to 4-hourly—that is, as soon as the necessary quantity can be divided over five feedings. The feedings should be human milk, if possible the mother's own milk. No artificial food should be even contemplated; if there is a shortage or delay in the establishment of lactation, the infant is far better to be kept going on water or a fluid such as sugar solution, than to upset its exceedingly delicate intestinal tract with foreign foods.

UNTOWARD SYMPTOMS

Vomiting: The first difficulty we encounter as a rule in feeding during the first three days is persistent vomiting of everything—water, milk or sugar solution. Feeding should not be discontinued, however, but often the distressing condition can be stopped by washing out the rectum with warm saline solution (about 3 ozs.). If in spite of this, vomiting continues, and the temperature becomes more and more subnormal, catheter feeding must be undertaken.

A catheter feeding should not be repeated under four hours; water should be given in between with a pipette, and such feeding should not be continued for longer than two or three days as the only means of feeding, but one or two feedings in the 24 hours may usefully be given by this method for two or three weeks if the child is very weak, especially before the long interval at night.

Over-feeding. Over-feeding rapidly produces vomiting and diarrhoea, and if this misfortune happens, water only and sugar solution for twelve hours and a very gradual re-establishment of

breast feeding must be the line taken.

Drugs are best avoided.

Cyanotic Attacks: The next difficulty one meets will be sudden occurrence of a severe cyanotic attack, in which the baby nearly dies. These are caused by atalectasis or more often by inanition. The cyanotic attack occurs usually just after a feeding, and is caused probably by a slight regurgitation, with which the infant has not strength to contend, and the very shallow breathing is seriously affected. The mouth must be cleared, and rapid artificial respiration performed in the cot. Camphor or oxygen should be given at once, if only atalectic. If the child cries it soon recovers, but close observation of such a child is necessary.

Liability to Infection: The liability to infection must also be borne in mind. Pneumonia, enteritis, eye infection, nasal and bronchial catarrh are often fatal complications, and can be avoided only by the most rigid cleanliness and thoughtfulness. Any nurse or friend who has a cold in the head or influenza must not be allowed to bend over the child. If the mother gets a cold she must wear a mask while feeding the child.

We add a note from Mary M. Richardson who took her training as a midwife under Miss Cashmore.

"The premature babies at the British Hospital are placed in a large, airy, sunny nursery with the normal babes. This nursery is kept at a low temperature as compared to our nurseries, and no attempt is made to warm the air supplied to the prematures, although heat is applied around and under the child."

The Technique of Breast Milk Expression

By Herman N. Bundesen, M.D., Sc.D.
Health Editor, Chicago Daily News

THE breast-fed baby is the best-fed baby. Mothers nowadays are realizing more and more the need for breast feeding. Unfortunately, there are many who, for one reason or another, are unable to supply the baby's needs. During the first few weeks of life the flow of milk often exceeds the baby's demands. Unless the breast is emptied after the baby finishes nursing, it will remain partly filled with milk. As a result it will fail to maintain its secretion and finally the flow will stop altogether.

On the other hand, the infant may not be especially vigorous and therefore unable to empty the breast.

In both instances, manual stripping, or emptying of the breast by hand expression, is the one measure which will maintain the breast milk supply until there is an adjustment between supply and demand. It would indeed be well if every young mother knew the art of emptying the breast by hand.

The following technique is the one most generally used:

The hands must be scrupulously clean and the nails cut short and smooth. The breast is grasped gently, just back of the dark part or areola, with the ball of the thumb in front and the index finger under the lower surface. The thumb and index finger are then pressed gently together, squeezing the breast between them. When the two fingers nearly meet, they are drawn suddenly but gently toward the nipple. The above motion is repeated about forty to sixty times a minute and is kept up until all of the milk is out of the breast. It usually requires a few minutes of effort before the milk begins to flow, but, when once started, it will flow freely and abundantly with each motion. The milk should be collected in a clean cup or bowl that has been sterilized by boiling. The milk must be kept covered and on ice until used.

This method of milking the breasts is of special value to the working mother who is forced to be away from her newborn baby most of the day. It

is possible for the mother to nurse the baby early in the morning before leaving for work. Then, while at work, at the regular nursing time, the breast may be stripped by hand. If possible, the milk should be saved and given to the child the next day, while the mother is away. Of course, in this case an ice-box at the place of employment would be essential. But even if the milk could not be saved, the supply would be kept up so that the baby could get at least two breast-milk feedings daily.

There are hand breast-pumps but their use has been almost entirely replaced by manual expression. Mechanical pumps, run by water power or an electric motor, are of value and are being extensively used in hospitals with good results.

Breast Feeding

Editorial Note: We are printing these notes on breast feeding contributed by Mary M. Richardson, R.N., who has just completed her midwifery course in England. These are notes prepared for the use of midwives, and have many points of value for nurses in the public health field.

For promoting an adequate breast milk supply it is of the greatest importance that the nurse foster a *desire* on the part of the mother to suckle her child. During pregnancy the breasts should be washed daily with hot and cold water, and rubbed briskly with a dry towel. Towel and face cloth are kept separate for this purpose. After the seventh month the nipples should be anointed daily with some emolient, preferably yellow oxide of mercury, and gently pulled out. In the case of inverted nipples this treatment should be repeated twice daily during the last two months.

POST-PARTUM DIRECTIONS

The baby must be put to the breast at regular intervals, in order to establish the habit of suckling. These intervals may vary with the size and strength of the child. The four-hour interval is preferable for the normal seven-pound infant. The mother should sit up to nurse her baby (unless there has been some laceration of the perineum). The baby should be held across the mother's lap. This position will encourage involution and proper drainage and is comfortable for baby.

The baby must be made to grasp the whole nipple firmly, not just chew the top of the nipple. This is easier for the baby if the mother supports the breast from underneath with her free hand.

Both breasts should be used at one feeding. Usually ten minutes at each breast. One breast must not always be taken first. The nipples should be cleansed with boiled water before and after feeding and dried carefully after. The mother's hands should be washed before handling her breasts. Breasts should be covered with a clean cloth afterwards.

The mother should make a habit of drinking a glass of water each time she feeds the baby.

DIFFICULTIES

What difficulties may occur?

Baby will not suck properly

The nurse should look to see if baby is tongue tied. If this is so, then it should be attended to. Perhaps the baby is sleepy and lazy. The mother must be encouraged to keep the baby awake during feeding time, and to sit him up after he has taken the first breast, in order to raise gas. The baby should be dry and clean before putting him to the breast. He should be held close to the breast and a little of the milk squeezed out in order to start him off.

Caked breasts

Treatment: Fomentations, support, restrict fluids and clean out bowels.

Nipples

If tender, treat with glycerine of boracic; if cracked, paint with tincture of benzoin if superficial, with iodine or silver nitrate if deep. A nipple shield may be used temporarily, but should be discontinued as soon as possible, or the milk supply will fail. If nipple bleeds, the child should be taken off

the breast, and the nipple painted with iodine and kept dry.

Insufficiency of milk supply

Make mother take a well balanced full diet.
Give plenty of water to drink.
Strip breasts after each feeding.
Apply hot and cold fomentations.
Use Truby King massage. (A series of massage motions to increase the supply of blood to the breast. This massage was first worked out by the Plunket nurses in New Zealand and is now widely used in England and on the continent.)

Mastitis

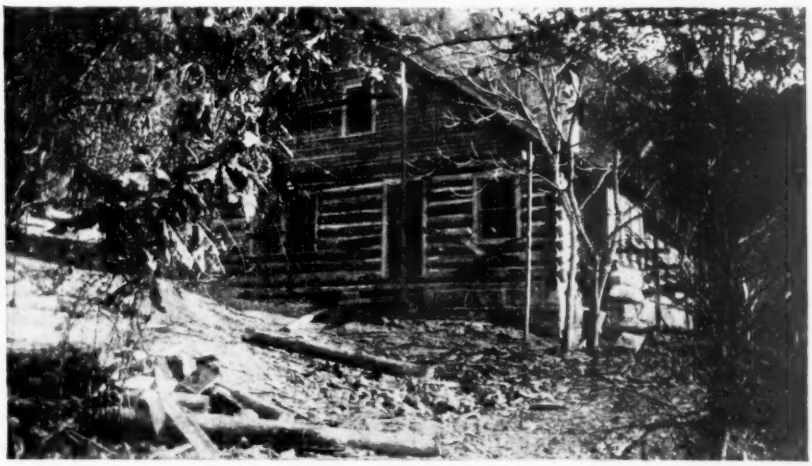
Rest the breast.
Support the breasts firmly.
Give salts until diarrhea is established.
Put the baby in another room.
Apply ichthyol and glycerine.
Return baby to the good breast as soon as temperature has been normal for twenty-four hours, and to affected breast after one week.

Too large a supply of milk:

Put baby to breast for a shorter period.
Apply firm binder.
Restrict fluids temporarily.

A DISTRICT NURSING CENTER IN THE MAKING

The Clara Ford Center on Red Bird River in Clay County, Ky., is the fifth to be built by the Frontier Nursing Service in organizing its initial territory of a thousand square miles.



The Clara Ford Center

The nurses have just moved over from their two-room cabin, where they have spent the first two and a half months since their local district committee was formed and the work was launched. They are living in the house as it stands in the picture, without heat, light or water, and with the doors propped up until the hardware arrives. But they have in compensation the most beautiful view of the windings of a lovely river.

As an instance of splendid coöperation, we would like to cite the results of these first two and a half months in a district eighteen miles from the nearest doctor, railroad or automobile road. Through the efforts of the local district committee of mountaineers, over 1,600 inoculations have been given against typhoid and diphtheria. Several patients have been sent to distant doctors and assistance given a doctor who came in on consultation. First aid was rendered a number of times and all sick calls have been met and over 500 people enrolled. In addition, 14 midwifery cases are registered, and seven have been delivered safely of live babies. Such accomplishments are only possible with the strong backing of leading local citizens.

—Mary Breckinridge

Prenatal Classes in a Hospital Clinic

Conducted by a Public Health Nursing Organization

By Ruth B. Wood
Director, Maternity Center Association, Brooklyn, N. Y.

As an experiment in team work, the Maternity Center Association of the Borough of Brooklyn and the prenatal clinic of the Methodist Episcopal Hospital of Brooklyn have undertaken regular classes of instruction to patients registered with that hospital for prenatal care and delivery.

These classes in prenatal care and maternity hygiene were begun by the Association in the clinic of the hospital on October 31, 1927, because each of the two institutions recognized a need and an opportunity. The hospital administration realized that patients might be better prepared for the profession of motherhood by accepting the offer of the Association, and the Association saw an opportunity to spread prenatal instruction to patients living in an almost limitless area, as the Borough of Brooklyn has no health zones, and each hospital receives maternity patients from any part of the Borough. The subject matter given follows the standards of the leading nursing organizations interested in the care of prenatal patients.

The first steps in effecting the affiliation were begun in the Spring of 1927 when the executive director of the Association met in conference with the chairman of the Medical Advisory Board to discuss the subject. A tentative letter was drafted to the obstetrical chiefs of three of the largest of the proprietary hospitals having maternity services in the Borough. This letter presented a detailed outline of service which the Maternity Center Association could offer to these hospitals. Following this letter, a small working committee of two board members with the director of the Association was formed in order to work out the next steps. Then the obstetrical chiefs and hospital superintendents or their representatives were visited and the detailed outline of the service offered was interpreted and amplified by the director. Within one week one hospital signified its serious interest in the proposed project and requested that definite steps be taken toward crystallizing the plan for the affiliation on a six months' experimental basis. With the vacation period at hand and short staffs in both hospital and nursing organization, it was decided to begin the classes in the autumn. The registration clerks and nurses in the clinic began to invite the patients to the classes which were to start on October 31st, one hour before the clinic. The hospital administration arranged for a larger seating capacity in the waiting room and prepared a line, wall space, and a table for the display of the teaching exhibit to be supplied by the nursing organization. In short, a generally receptive attitude was apparent throughout the hospital.

PROGRAM OF LESSONS

In order to teach *all* of the patients registered for care, three types of teaching program were tried.

The first, which soon proved its own inadequacy, provided for but three subjects for classes: *Prenatal Care, Postnatal Care* with a review of prenatal care, and a *Demonstration of the Baby's Bath.* This was tried for a few days until it was seen that interest on the part of the mothers was so keen that much more detail would be welcomed by them.

The second type of program was then tried. These lessons were given to the group according to the needs of the particular group present; for example, if the majority present had not seen the baby bathed, that talk with demonstration was given and

so on, until all the subject matter was covered for the greatest number possible. This type of program also was replaced by still another in order that the greatest number might receive the complete course of instruction.

The third type is the one in use at present and seems to fill the need satisfactorily. At the beginning of each month, the program of classes is worked out on a weekly basis and for the five clinic mornings during each week, the same talk is given. The class program is posted in a conspicuous place in the waiting room, so that each patient may know just what day or week, each demonstration will be given. In this way if a patient feels the need of more instruction and a repetition of a demonstration she may drop in for the class even though she may not want to stay for clinic.

The question of record keeping in these classes, carried by the Maternity Center Association had to be met at once. Because no home visits are being made as yet, any detailed record is not possible. A 3″ x 5″ card, carrying the patient's name, address, date of expected confinement, date of the first visit to the class and subject of talk given with dates of subsequent class visits, is the record kept for each patient.

NUMBER OF PATIENTS REACHED

The proportion of patients having received the complete course is large. This is probably due to several reasons, the most important being that the clinic service reaches many patients in the third and fourth months and these patients return regularly throughout their term of pregnancy. Also the nurses at the registration desk and in the clinic, as well as the resident obstetrician, join in urging the patient to attend these early morning classes before they are examined in the clinic. During the six months' experimental period, 761 patients were reached through the classes.

On May 1st, at the termination of the first six months' experiment, the nursing organization and the hospital maternity service seemed eager to have the affiliation go forward. As a result an affiliation was arranged for a second six months' period. During this period it was suggested that the classes be extended to take in the semi-private and later the private patients of the obstetricians attending at the hospital, these classes to be conducted in a separate class room. Private classes were begun on July 1st, and the registration has been slowly increasing. The patients in these classes are charged a small fee for their instruction which the nursing organization receives. Further extension of this educational program has been made possible only because of the remarkable vision on the part of the obstetrical chiefs and of the directress of the maternity wing of the hospital. The hospital deserves the credit for being the first to take advantage of an experimental affiliation which would mean an educational rounding out of the prenatal care already being given to the patients in the clinics.

RESULTS

The results of this experimental demonstration that are tangible at this early date, may be summed up as follows:

During the year of affiliation there has been a total of 1,181 patients, private and ward, who have received the instruction.

Two more hospitals have requested a similar service and this service has been initiated. At present two additional hospitals are negotiating with the maternity center for the inclusion of teaching in their clinics.

ANOTHER DEVELOPMENT

In carrying out this same plan of teaching prenatal care to an ever increasing group of prospective mothers, the Association carried on a piece of work outside its own organization last summer when it gave classes to the Kindergarten Mothers' Club at Coney Island during July. This new educational venture at Coney Island was sponsored by the Department of Education of the City of New York.

The care of the mother and baby throughout pregnancy and instruction of the mother in the care of her baby after birth, cover "the least that every mother should know." This subject matter was adapted to meet the needs of various daily groups which met at Coney Island Mothers' Camp during July.

Auntie Learns Some New Fangled Ideas

By Katherine E. Malone
Field Nurse, Bureau of Child Hygiene and Public Health Nursing,
State Board of Health, Columbia, S. C.

The first Midwives Institute was held at Voorhees School, Denmark, South Carolina, in July, 1927. Three Institutes were held in 1928 at the same place during June, July and August. Patients are supplied through the prenatal clinic which is held weekly at the hospital belonging to the school. In 1928, 75 midwives attended the school from 27 counties. The staff nurses each spent two weeks assisting Miss Malone and several of the county nurses were visitors. Forty-two patients were cared for. Every effort was made to keep the instruction simple and adaptable to all home situations.

"GOOD mornin', Auntie."

"Lord, child, wha you been? Peers lack I hear'd you been off learnin' some new fangled ideas. Whar'd you go?"

"I been down to Voorhees College in Denmark attendin' the Midwives' Institute fur a month."

"How come you went?"

"Well, it was this way: Down in Denmark they got a college for the colored folks. That's where Professor Martin Minafee and Professor J. E. Blanton lives. Well, they got a white man down there named Dr. Joe Matthews and a health nurse named Miss Malone what sho knows their business. Every Monday they holds a prenatal clinic in connection with the school and under the direction of the Bureau of Child Hygiene."

"I ain't never seen a bureau like that in nobody's house."

"If ignorance is bliss, then you ought to be blistered. Nigger, that's a department of the government what looks after the children. Well, in July they decided they would hold an institute there and invite midwives from all over South Carolina."

"Who told you 'bout this and how come they never axed me to go?"

"Auntie, you can't read and write, anyway they 'specially invited young midwives. They inquired about our characters and we each had to pay ten dollars board for the month. The health nurse in our county told them about me. I sho am glad we got a nurse in dis county. There were twenty-seven of us midwives who attended the institute who came from seventen counties. Nurse Boisfeulette was there also."

"Nurse Boisfeulette? Who's she?"

"She's the colored nurse at the school and they thought so much of her that her salary for three months was paid a part of the time by the women in the Episcopal diocese who were interested and a part of the time by the government."

"What did you all do down there fur a whole month?"

"We were divided into three groups, but we called ourselves tribes. One was the cooking tribe and we cooked and served the meals and took care of

the kitchen and dining room. Two women served in the director's dining room and kept her bed room. I was captain and had charge of the supply pantry and didn't have to take orders from nobody but the director. The menus were made out the day before and given to me."

"Menus? What's dat?"

"Nigger, your ignorance is refreshin'. That's the eatens for one day. The second tribe did the washing and the ironing and took care of the dormitory. The last tribe was the nursing tribe and took care of the patients, cleaned the wards, bathrooms, halls and porches and served the patients' trays. I liked this work best. Every ninth day the tribes had to change places."

"Well, I could have done all of that. How come you had to know how to read and write?"

"I ain't told you half. We rose at 5:30 and ate an hour later and served the director's breakfast at 7 o'clock. We went to chapel at 8:30 and stayed until 9. From then until 11 we cleaned up the hospital and took care of the patients and during this time the nursing group had first aid. At 12 we had dinner and gave the directors theirs, also the patients. From 1 to 2 the cooking group studied the symptoms of contagious diseases and had cooking from 2 to 3. We studied midwifery from 3 to 4 and personal hygiene after that."

"Just because you been off and larned a whole heap of big words what don't make no sense, you think you knows everything."

"We sho did hate to break up school cause we had such a grand time. They made us stand a written examination and all but one woman got a certificate. Three equipped bags were given to the three makin' the best grade. I got one and I sho' was proud of it."

"Were they real patients you had or did you just make out like dey was?"

"They were real patients and they showed us exactly how everything was done."

"Did you put an ax under the mattress to cut the after pains and tie the husband's pants around the wives' necks to make the labor easier?"

"No, we didn't. I used to think all that had to be done, but I know better now. White folks and doctors don't do it. It don't help none and is an old fashioned idea."

"Maybe you is right, child. I'se just been raised dat way."

"So had I, but now I've seen the light and now I intend to pass it on to the rest of our race. I'm going to show everybody the bag they gave me and try to teach the midwives around here all I know."

"Bless the Lord, child, you'se right. Don't forget I wants to see the bag. Goodbye, honey."

"Goodbye, auntie. Come again."

THE OXEN

Christmas Eve, and twelve of the clock.
"Now they are all on their knees,"
An elder said as we sat in a flock
By the embers in hearthside ease.

We pictured the meek mild creatures where
They dwelt in their strawy pen,
Nor did it occur to one of us there
To doubt they were kneeling then.

So fair a fancy few would weave
In these years. Yet, I feel,
If some one said on Christmas Eve,
"Come; see the oxen kneel

"In the lonely barton by yonder coomb
Our childhood used to know,"
I should go with him in the gloom,
Hoping it might be so.

—*Thomas Hardy*

Education—By Request

By J. Martha Kessler
Obstetrical Supervisor, Visiting Nurse Association, Milwaukee, Wis.

The Habit Training Club for mothers, which is conducted under the direction of the Obstetrical Department of the Milwaukee Visiting Nurse Association, grew out of the prenatal conferences with our expectant mothers. After the birth of their babies a group of mothers returned to ask whether it would be possible for them to continue coming to the prenatal conferences for further advice in caring for their new infants. It was rather difficult for the nurse to give the prenatal instructions and habit training at the same conference; after some deliberation the nurse suggested to the group that they consider organizing for the purpose of further study in the care of the child. This plan was accepted with great interest and it was decided that the mothers meet monthly on Wednesday afternoons at the branch office of the Visiting Nurse Association.

Our first class, November, 1927, was very informal; seven mothers and their babies were present. The nurse gave a talk on the "Instincts of the Child," and led the discussion. A topic was assigned to a member for the next session. At the close of the meeting refreshments were served.

At the following meeting the members decided to organize; a president, secretary, and program chairman were voted upon (the program chairman to confer with the nurse). By March, 1928, we increased the membership to sixteen. In April the entire group subscribed to "Children—The Magazine for Parents," and a bibliography was sent to us from the Merrill-Palmer School. Our Public Library is a great help; the majority of the members using library cards.

It was voted to dispense with the July and August study meetings each year, and devote the regular club day to outings for the children; the July meeting to be a children's picnic, and the August meeting a bathing party.

At the September meeting the officers presented the rules covering the following points:

Name, membership (22), time and purpose of meetings, officers (president, secretary, treasurer and program chairman), dues (ten cents a month to be used for children's summer outings); a nurse to be present at each meeting to head the discussion.

Each mother took her turn in caring for the children present during the discussion hour. This plan was not entirely satisfactory, however, so at the October meeting it was decided to change the time of meeting to an evening hour, so that the children could be left at home with the fathers. The November meeting was an evening meeting, and all the mothers agreed that it was highly successful.

The topics for discussion have been assigned to the members in alphabetical order; and are as follows:

Sunshine and Rickets.
Sleeping and Eating; Candy Habit.
Punishment of Children.
Children's Diseases and Their Prevention.
Visit to Nursery School and the Need for a Plan in a Child's Life.
Posture—led by the orthopedic supervisor.

The mothers are alert, and easily grasp the subjects (most of them were stenographers, bookkeepers and 2 had some university training before marriage), while the nurse in charge has been greatly stimulated by the discussions. For the next meeting a member will speak on "Modern Youth Needs Modern Parents," and a speaker from the Milwaukee Speakers Bureau will speak on "The Misunderstood and Misunderstanding Child." The members have also agreed to have a physical examination of all their children by January 1, 1929. The total membership to date is twenty-two.

A County Health Nurse Program *

By Gladyce Badger
Washington County Public Health Nurse, Salem, Indiana

I AM a county nurse in Washington County, located in southern Indiana. I live in Salem, the county seat, which has a population of 2,800 people, and is thirty-five miles from Louisville, Kentucky. There are many wonderful things about this county. The country is beautiful at all times but now with the turning leaves it is indescribable. Always of interest to me are the old historic places, the spouting springs, the old, old log houses and many caves. Better than all these are the wonderful real people in southern Indiana, and Washington County. I have found the greatest hospitality there.

This may not seem to have much bearing on a county health nursing program but I am sure the nurse who is happy in her home and social life is much better able to do a good piece of work than the one who is not. So in planning a program, a nurse should always leave time for recreation. A hobby such as music, golf, or tennis is to be desired.

Washington County is large, having a population of 17,000 people and is twenty-five miles square. It has eighty-three schools and seventy-one of these are one room school houses. About half of these schools are on mud roads which are impassable all winter and until late in the spring.

Being the only nurse or social worker in this whole community, I am expected to do all the school nursing in these eighty-three schools which include 4,500 school children. I am also expected to do tuberculosis nursing, give prenatal advice, child welfare, hospital follow-up, besides other educational projects. It would be useless for me to try to tell you who have had experience in all these different phases of nursing that I effectually carry out all this work alone, for a population of 17,000. It is *impossible* for a nurse alone to do all there is to be done in her county. Because of this she must plan a program which will fit her needs and resources. The program which I have planned for Washington County may not fit your county. Every nurse must plan her own program.

PLANNING A PROGRAM

There are three points any nurse may use in planning a program. They are, plan it for a whole year; plan the work to live on after the nurse leaves; and if possible add a new project each year.

In deciding on one's plan for a year a nurse must take time for thought. It is a mistake to go into a community one day and plan the program for the year the next. Results are better, coöperation greater, and work easier, when the problem which the people want solved is attacked first and ideas developed later.

I am glad I started work in Washington County in the middle of the year. It rained for two months, mud was deep in the outlying districts so I had time for thought.

I made my first call on the Health Officer. He had a very small office on the second floor of the court house and told me I might share it with him or have my own office in the old Red Cross room. On visiting the latter I found dust many inches thick, no heat, and a long uninviting stairway leading to it. I decided the room at the court house, although small, at least had linoleum on the floor and a radiator. So an old desk was moved up for me and a couple of chairs were donated; the proprietor of the hotel being quite artistic painted a sign, "County Health Nurse," which now hangs outside the door.

The first week or so I spent in

* Paper read before the Indiana State Nurses' Association, Indianapolis, Oct. 13, 1928.

getting adjusted, ordering literature and school records and first aid bag. My friend, the Health Officer, when I was wondering what I would use for a school bag, kindly offered the little square case in which he carried pills when practicing. It served the purpose very well.

SCHOOL VISITS

A month passed by before I had a car so my first school visit was made by train. It was raining. The school house was a modern one but on top of a large clay hill. I remember how sticky the mud was as I walked up. I had no scales so one of the boys borrowed some from a grain and poultry store and we used them all day.

This school visit made me wonder where I could file my records:

I secured three large black paste-board boxes and white paste board from the printing office. I cut the paste board in pieces to fit the box and labeled each piece the name of a township. These boxes were an exact fit for the school and tuberculosis records and have served the purpose well. However, I am glad to say I am looking forward to something better. The Manual Training Department of the Salem High School is making me a filing case of *real wood*.

I cannot tell you in just a few words all the things I learned in the first six months. I became acquainted with prominent people and leaders in the various communities, location of schools, roads, names of townships, etc. More valuable than all, I learned that the *people* wanted tuberculosis work done in Washington County. So the second year began with our program for the year covering school work, and tuberculosis work, including reorganization of the association, clinics and home calls.

Our organization is not yet what we would like it to be but we have a township chairman in each of the thirteen townships and an executive board which meets once a month. The chairmen are called together only once a year at the big, annual meeting. Our second annual meeting is just over and was inspiring because this year the attendance was nearly doubled. Each township chairman brought a neighbor. We try to have an outside speaker and a short report of the past year's work.

We felt our tuberculosis work was really started when we were able to establish tuberculosis clinics. It was rather difficult to find a time when our doctors were all together for a discussion of the question. At last the opportunity came when they met to make plans for a regional medical meeting to be held in Salem. At this meeting they expressed themselves in favor of a clinic and suggested an outside clinician as they were all very busy. So we had a clinician come from Indianapolis. We held our clinics in the court house, using the court room for a waiting room, judge's office for taking histories and jury room for examination. The men undressed in my office and the women in a portion of the judge's office behind a bookcase. The women township chairmen took turns in assisting at the clinic. Six clinics have been held in Washington County this last year and the attendance has been perfect. Every clinic has been full to overflowing.

VALUE OF RECORDS

After our clinics had been going for some time I wondered what part of Washington County we were really serving. Were we serving Salem or all of Washington County?

I secured a map from the Post Office Department, Washington, D. C., and had it mounted on beaver board. Each death from tuberculosis for the last five years is designated by a black pin, each active case at the present time by a red pin and present suspicious cases by a white pin with red center. Knowledge of the latter came through the clinics only, as cases are never reported to me by the doctors unless really active and usually far advanced. So by looking at the distribution of these white pins I am able to say our clinics have served Salem mostly and the southern half of our county. It will be time well spent this coming year to hold a few clinics in the northern part to teach the people there what they really are. This map has been of real value to me and has created much interest.

We know that the value of a tuberculosis clinic lies not altogether in the clinic itself but in the follow-up visits

made by the worker. After several clinics I found my follow-up visits were threatening to overwhelm me. It was impossible to remember them all, or when they should be called on, or the advice I had given on previous visits. So some system of records was imperative. This was especially important if I wished my work to live on after me.

Records are a problem for any county nurse because of lack of time but to neglect them entirely seems to me a grave mistake. When I first came to Washington County I did not know all the tuberculosis families. I heard of one here and one there but it was months before I realized many of them belonged to the same family tree. Why should another nurse spend months learning the names and location of tuberculous families? She should be able to take up the reins and drive on from where I leave off.

Each tuberculous family in our county now has a family folder telling names, ages and condition of health of all children. A nurse coming to the county ten years from now can easily see that little Johnnie was in contact with his mother (an active case) when a baby. She can also see he was examined at the clinic in 1928 and was pronounced sound. This folder also contains record of follow-up visits of the nurse, the clinic examination blank, and the sputum reports from the laboratory. Our system of records is not elaborate but it satisfies our needs at the present time.

BUILDING FOR THE FUTURE

In addition to some system of records a nurse should educate her public in order that her work may live after her. To do this she must not only send articles to the newspapers but she should talk on every occasion. She may not be a public speaker but if alive to her work she must be full of her subject and just to tell it in ordinary language is always interesting to people when it concerns home problems.

After working two years in Salem I decided that with all my talking, people did not know enough about my work. So each month when making out my report for the state department I write a narrative report telling all the interesting things I have done during the month. I also report the number of schools visited, home visits, and of visits to tuberculous cases, etc. The high school coöperates by making thirty copies which I send to each county commissioner, each member of county council, township chairmen and members of the executive board of the Tuberculosis Association. I feel that this will give those responsible for my being in Washington County as health nurse a broader vision of what I am trying to accomplish.

NEW PROJECTS

If possible a nurse should add some new project to her program each year. This serves to refresh the worker herself and interests a new group of people. The new project in Washington County this year is the instruction of classes in Home Hygiene and Care of the Sick, carried on under the Red Cross in our county schools. This is a rotating service, only two schools being chosen each year. Both junior and senior girls are taught once a week for one semester. Next year these two schools will be eliminated because their juniors will have had the work, and the remaining schools will be taken up. The girls all seem very interested and are planning to give a play as a public demonstration before Parent-Teachers Association and Farmers' meeting. Each girl is required to make a poster which is displayed at the county fair, afterwards to be used in health talks in the country schools.

SATISFACTION AND JOY

I am not here to tell you that county nursing is the only interesting branch of nursing. All phases have their glory and satisfaction. Every nurse should be guided by her own feeling as to whether or not the type of work she is doing suits her and gives her complete satisfaction. Our profession is too big and offers too many opportunities for any of us to drift and not give all we have in us to our work. After all, real happiness is happiness in work. I am sincere when I tell you I have never felt such joy and thrill as I feel as a county nurse, and I am glad that I am one.

Outline of Course for School Nurses

PREPARED JOINTLY BY BEATRICE SHORT, ASSISTANT DIRECTOR OF THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, AND ANNA L. STANLEY, CHAIRMAN OF SCHOOL NURSES' SECTION

Approved by the Education Committee of the National Organization for Public Health Nursing

At the request of the Education Committee of the National Organization for Public Health Nursing a tentative outline of a course for school nurses, covering four summer terms and winter extension work, was prepared and submitted. It was planned that the courses included in these four summers should be definitely progressive in character and should contain the generalized material which is the basis for all public health nursing. The School Section of the N.O.P.H.N. Manual of Public Health Nursing and "Present Objectives, Scope of the Work and Methods in School Nursing," * served as the criteria of needs to be met.

A copy of this tentative outline was sent to 18 representative nurses in different parts of the country asking for criticism both as to content and as to sequence. The suggestions from this group and from the Education Committee itself contributed to the following outline which was definitely approved and adopted late in September.

This course covers a special field of public health nursing and cannot be considered the equivalent of the basic course, inasmuch as it does not meet the minimum requirement for supervised field experience. Nevertheless, the Education Committee of the N.O.P.H.N. offers the outline with the hope it will prove suggestive to those planning summer courses for the school nursing group.

KATHARINE TUCKER, *Chairman, Education Committee*

First Summer

1. *Principles of Public Health Nursing:* Present Objectives, Scope of Work, Organization and Methods in School Nursing. 2 Points.
2. *Family Social Work:* The effects of social disabilities on the family; case method of handling problems; discussion of living standards. 2 Points.
3. *Child Health:* Standards for normal health and development including habit formation. Discussion of communicable diseases, health hazards and nutrition problems. 2 Points.

or *Educational Psychology.*

Suggestions for Additional Courses for Summer or Extension Work in Winter.

Practice work in School Nursing under Educative Supervision. 2 Points.

English Composition. 2 Points.

Public Speaking. 2 Points.

Second Summer

1. *Methods of Health Education in the Elementary Schools.* Adaptation of subject matter and methods to health education. Consideration of various devices used in health teaching. 2 Points.
2. *Educational Psychology:* Elementary psychology with special emphasis on professional situations. 2 Points.
3. *Nutrition in Health Education:* Includes essentials of adequate diet and food needs for different ages. The nutritive value of food materials with regard to application of such knowledge to health education. 2 Points.

or *Mental Hygiene*

Suggestions for Additional Courses for Summer or for Winter Extension Work.

Practice in Family Social Work.. 4 Points.

(This would require a full month's work under Educative Supervision.)

* THE PUBLIC HEALTH NURSE, February, 1926.

History of Education: Introduction to educational problems in a democratic state with special reference to our own national situation. The increased responsibility of the State for education. 2 Points.

Advanced courses desirable.

Educational Methods: Continuation of above. 2 Points.

Third Summer

1. *Mental Hygiene.* Development of personality: deviations in personality and behavior disorders of childhood with reference to prevention and adjustment. 2 Points.
2. *Child Psychology.* 2 Points.
3. *Educational Sociology:* Social and human origins as backgrounds for consideration of problems of modern society and the sociological method of approach to them. 2 Points.

Suggestions for Additional Courses for Summer or Winter Extension Work.

Practice work on staff of visiting nurse association under educative supervision (2 months). 4 Points.

Practice work in Health Education under educative supervision. 2 Points.

Physical Education: Folk dances, stunts, team games. 2 Points.

Additional course in *English.* 2 Points.

Fourth Summer

1. *Public Health Nursing:* This course should give a broad understanding of the many phases of public health nursing, their relation to each other and to educational and social improvement. The organization of public health nursing under official and non-official agencies. The advantages, plan of organization and work in a completely generalized or partially generalized service. 2 Points.
2. *Personal Hygiene.* 2 Points.
   or *Biology.*
3. *Organization and Supervision of Health Education:* Principles governing health education in relation to the rest of the educational program. Criteria for selecting materials and activities. Departmental correlation. 2 Points.
   or *Teaching of Home Nursing* and *Child Care Classes.*

Suggestions for Additional Courses for Summer or for Winter Extension Work.

Public Health Administration and Preventable Disease. 2 Points.

THE CHRISTMAS SEAL

What treasures of art and literature have been lost to the world through the ravages of tuberculosis! That "tuberculosis loveth a shining mark" is evidenced by this list of famous persons who either had or died of the disease. Ralph Waldo Emerson, Elizabeth Barrett Browning, Alexander Pope, Honore de Balzac, Washington Irving, Robert Louis Stevenson, Charles Kingsley, Lord Byron, Moliere, Chopin, Keats, Shelley, Goethe, Schiller, Raphael, Heine, Thoreau, Paganini. Their average life span was but 51 years.

Returns from the sale of Christmas Seals provide better diagnostic and convalescent facilities. Who knows what masterpiece a purchase of seals will salvage for the artistic enrichment of our lives?

When I muse on Trudeau I don't think of him as a saint—he was none; nor as a builder—details irked him and Daniel Riddle loomed large here; nor as a practitioner—and few have ever excelled him in native ability; nor as a scientist—and he was a great one. I think of the man who would ease the dying patient's path into eternity; who would relieve and reëstablish the young widow and her children, "stranded" in a bleak and far-off country; who in every weather would point his little boat up the St. Regis lakes to speed to the suddenly stricken millionaire and with him stay out the night (his charge would be $3); who, in the autumn of 1884, placed two factory girls in the "Little Red," and then and there began a service of personal attention that ended only with his death; who, devoutest of churchmen himself, measured no man or woman by Romish, Lutheran or Calvinistic yardstick, but according to the single rule of whether they were honestly following their best instincts. At whatever point you start to gain an insight into what Trudeau was and did, you enter a path that leads to the same end—his humanity.

Allen K. Krause, M.D., The Journal of the Outdoor Life

The Sixth International Congress of the Union Against Tuberculosis

By Juliet Turner
Florence, Italy

THE setting for the Sixth Conference of the International Union against Tuberculosis, held in Rome, September 25–28, 1928, was indeed imposing. The Eternal City spread her sunshine around us, and the very stones of the Forum seemed gay, as the crowd of doctors from 39 different nations passed to and fro on their way to the meetings.

The nurses also were conspicuous. For this occasion, the Volunteers of the Italian Red Cross donned their dark blue uniforms, responding to the call of their head, H.R.H. the Duchess of Aosta. The blue and white pupils of S. Gregorio, the blue and white also of the Red Cross Training School, turned out nobly, and from all over the country, the *Assistenti Sanitarie*, or public health nurses, at no little personal inconvenience and some financial sacrifice, came to attend the meetings, which touch their work so vitally. The Training School of Venice was well represented, an efficient looking group, with their Directress.

Finally, an important representation of foreign nurses was present. Mrs. Bedford Fenwick, Miss E. N. Musson, from Great Britain, Mlle. Chaptal from France, and Miss Christiane Reimann, Secretary of the International Council of Nurses, are familiar faces wherever nurses are met together. Here they came not officially as members of the I.C.N., but as well wishers and friends of Italy.

It is now possible to say that the formation of an Association of Italian Trained Nurses has presented many difficulties, but it is hoped that with the recently aroused interest of the Women Fascisti, these difficulties may be overcome.

In the meantime, one cannot but admire the work which is being done under conditions which might well baffle an expert, and against which these valiant women carry on. It came upon us, who work in Italy, as a surprise to hear one of the English nurses speak of good food spoilt by the cooking, of tempting an invalid, etc., while our public health nurses know that in case after case, when the wage earner of a family is ill, any food at all is a problem, and a few milk tickets are a treasure. Cooking as cooking presents no difficulties to the Italian woman; she is a born cook, and curiously enough, she seems to have some instinctive ideas which are useful if there is illness in the house. Every woman knows how to make a poultice. But unlimited food she does not have to give. It came also to us as a surprise that people can be easily accommodated in hospital, while with a death rate of 65,000 from tuberculosis, we in Italy have but 1,600 beds in the country to accommodate the tuberculous cases. All this, and much more, we hope, indeed, we expect, to be modified under the new law which enforces compulsory insurance against tuberculosis.

Other countries told us during these days of what they have accomplished, and what strides are being made in the fight against tuberculosis and Signor Mussolini, in his opening speech at the Capitol, told us that the Fascist Government intends to provide what is necessary in Italy. Perhaps this is digressing from the Congress; but in this International Congress the nurses have had a real part.

Over 400 nurses from seven countries were represented—France, Great Britain, Irish Free State, Italy, Luxemburg, Poland, and the United States.

Mlle. Chaptal enforced the point that a nurse's powers of observation greatly depended upon her degree of technical

knowledge, and stressed the necessity of adequate preparation. The reading of Miss Borne's paper was followed with close attention. As Matron of Papworth Village — the tuberculosis colony and Village Settlement at Cambridgeshire, England—and delegate of the College of Nursing, she could indeed speak as one in authority.

The various excursions which we made showed fine institutions, many patients, and many nuns in charge. At Anzio, the public health nurses train for work in the malarial districts. But training schools are few, and all graduate nurses are immediately snapped up. The Red Cross is striving to start more schools, and an excellent school at Venice functions in connection with the hospital. At Rome the School at the Policlinico is going on as usual, but all this is not enough. However, it is a good sign that in the training school in Rome they have almost too many pupils for their accommodations at this moment, and they are all bright, alert, intelligent looking young women.

A few words as to the meetings. A crowded meeting at which Professor Calmette spoke of the infiltration of the virus into the placenta during gestation, and discussed the point as to whether such infiltration might or might not confer immunity to tuberculosis, was followed by a lively and varied discussion.

The organization of preventive measures in rural districts received considerable emphasis, 48 papers being devoted to this subject!

Ministro Martelli explained the workings of the new law on compulsory insurance, which he says is to be considered as of a tentative character, and will be modified if it does not produce the results of lowering the death rate, which is too high in Italy, some 65,000 annually from tuberculosis. This law is just coming into force, and all employees must be insured, at an expense of $1.50 a year, half of which is paid by the employer. This should bring in three hundred millions of Italian lire annually, and is to be spent in building sanatoria, providing more beds in hospitals, and giving some home relief.

A little trio exchanging notes were from Texas, Little Rock, Arkansas and Stoke-on-Trent, England. The doctor from this last town was gloomy on the subject of possible recovery from tuberculosis. He said that in the pottery districts in England recovery practically did not exist, and that the percentage of deaths between the ages of eighteen and twenty-five was most depressing, and he advocated better housing conditions. Indeed, we all do that!

An interesting experiment has been tried by Professor Banfi, of Milan, with good results. He arranges shelters, where workmen can sleep in the open air, outside of the city, for six months of the year, having their last meal of the day also in the open air. In the morning the workmen take the trams into the town, and they find such benefit from this treatment, that they are loth to sleep indoors when winter comes.

It was so invigorating to hear all the accounts of what different people and different nations were doing, that we were sorry when the Congress came to an end, to meet again at Oslo in 1930. Professor Harbitz of Norway, as well as Dr. Opie, of Philadelphia, were elected as new members of the Board of Directors, the existing members being all re-elected. Prof. R. Paolucci remains as President until 1930.

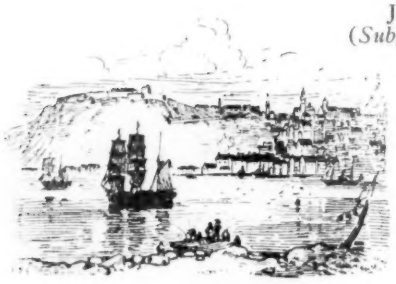
Editor's Note: We add a paragraph from a letter from Mlle. Juliette Lefebvre, League of Red Cross Societies, Paris:

"In his opening speech Prof. Leon Bernard stated that it now seemed quite impossible to think of any public health congress which did not include an important section devoted to the discussion of the problems of public health nurses. The program of the third day which comprised the social aspect of the campaign against tuberculosis was common to both doctors and nurses"

PRELIMINARY PROGRAM

Congress of the International Council of Nurses—Montreal, Canada,

July 8–13, 1929
(*Subject to alteration*)



Quebec

General Sessions (Afternoon and evening)—**July 8**

President's address, reports of Grand Council, Officers, Committees, and Addresses of Welcome.

General Session—July 9

Roll call by countries—Reports of affiliated organizations—Address: Exchange Scholarships.

Section Meetings

Nursing Education—The preparation of a curriculum—Trends and Developments in Vocational Education—The Community Need in Relation to the Education of the Nurse.

Public Health Nursing—The Red Cross Nursing Program—Developments in the Public Health Field.

Private Duty—The Status and Problems of the Private Duty Nurse.

(Speakers for the sections will be appointed from Asia, Australasia, Africa, Europe and America.)

General Session

Introduction of newly affiliated national organizations—Greetings from representative members—Address: The Future.

Round Tables—July 10

The Need of Education in Mental Nursing in the General Nursing Curriculum.
Utilization and Organization of Teaching Services in Various Public Health Activities Not Under School Control.
Economic Aspects of Nursing Education and Nursing Services.
Specialized Training for Private Nurses.
The Public Health Nurse and Social Work.
Text and Reference Books for Nurses.
The Place of Preventive Medicine in the Curriculum of the School for Nurses.
Staff Education.

General Session

University Schools of Nursing—Principles of Leadership—The Nurse as a Citizen.

Round Tables—July 11

Maternal Care.
Administration of and Instruction in Wards in Hospitals Not Under School Control.
Red Cross Nursing.
New Ideas and Devices in the Nursing Care of the patient.

General Session

Reports of affiliated organizations.

Section Meetings

Nursing Education—Legislation as Related to Nursing—State Supervision in Schools of Nursing—The Advisability of Standardizing Nursing Education.

Public Health Nursing—The Study of the Normal Child as a Preparation for Public Health Nursing—(a) Physical Aspects; (b) Mental Aspects.
The Citizen in Relation to the Public Health Program.

Private Duty—Developments in Private Nursing—The Financial Aspect of Medical and Nursing Services.

General Session

Community Organization for Health Work—The Scientific Method in Social and Health Work.

Round Tables—July 12

The Coöperation between Sister Tutors and Ward Sisters in the Training of the Student Nurse.
Nursing in Relation to Mental Hygiene from the Standpoint of the Community.
Health of Student Nurses.
Community Organization for Health Work.
Recreation and Other Activities of the Student Nurse.
The Purpose, Scope and Arrangement of Practical Field Work in the Training Course in Public Health Nursing.
University Relations in Schools of Nursing.
The Question Hour (Questions to be sent in by members of the affiliated organizations of the I.C.N. for discussion).

General Session

Adult Education—The Development of the Nurse in Service—The Need for Publicity in Nursing.

General Session—July 13

Reports from Round Tables—from Grand Council. Business session.

Closing Session

Introduction of newly elected officers—Addresses of farewell.

The complete program and speakers from the different countries will be announced later.

Annual Meeting of the National Committee for Mental Hygiene

Plans for the First International Congress on Mental Hygiene to be held at Washington, D. C., in May, 1930, were adopted at the 19th Annual Meeting of The National Committee for Mental Hygiene, held in New York City, November 8. Mr. Clifford W. Beers, Secretary of the National Committee and founder of the mental hygiene movement, announced that funds sufficient to guarantee the basic expenses of the Congress have been made available through the American Foundation for Mental Hygiene, a corporation recently organized for the support of national and local committees, institutions and agencies engaged in work for the prevention and control of mental and nervous diseases and the promotion of mental health in all parts of the world.

Speaking of the rapidity with which the mental hygiene movement has spread since the World War, Mr. Beers said that national committees, leagues, councils or societies for mental hygiene have been established or are being organized in 21 countries, besides the United States and Canada, and that all important countries will undoubtedly be represented by such agencies by the time the First International Congress is held.

Out of the Congress is expected to come an International Committee, with headquarters in this country, which will act as a clearing house for information on all phases of the subject and as the coördinating mechanism for the development of programs of activity and study in the field of mental hygiene for the benefit of all countries.

The establishment of a new philanthropic foundation, known as The American Foundation for Mental Hygiene, Incorporated, was also announced.

Dr. Arthur H. Ruggles, Chairman of the Executive Committee of the National Committee, characterized the project as a " permanent guarantee of the continuance of the work begun twenty years ago for better treatment of the insane and the feebleminded, the reduction and prevention of mental and nervous disorders and defects, and the promotion of mental health."

Report of the National Safety Congress

The Seventeenth Annual Safety Congress held in New York City in October was notable for the organization of three new sections. The Home Safety Section, which will have representation from national groups concerned with home life, has grown out of the recognition of the increasing number of accidents occurring in the home—in 1927 between 23,000 and 25,000. In one city, Erie, Pennsylvania, the home accidents in the last five years exceeded the combined traffic and industrial accidents. Public health nursing groups, because of their advantageous home contacts are becoming active in the safety education campaign. In Kansas City through the use of volunteers, and consultation at clinics, the Children's Bureau reached 25,000 homes in which preschool children were exposed to accident, and the parents' interest in prevention aroused. We hope to publish a description of the part public health nurses played in the home safety campaign in Erie.

At the meeting of the Health Service Division, announcement was made of a newly organized Division of Industrial Health, with Dr. C. O. Sappington as Director. The work of this division will consist of an advisory and guidance service in solving problems in relation to the health of the worker within the factory walls. Some of the proposed activities of this new division are: a correspondence service relative to health hazards in the various industries; a series of pamphlets; talks to foremen, executives, and to interested physicians and nurses; contacts with medical directors of various large industrial medical services throughout the country; plans for the administration of industrial medical services and perhaps later for mercantile health units.

The first Aeronautical Safety Conference was included in the National Safety Council program. Of the medical aspects of safe flying, Dr. L. H. Bauer said:

"Abnormalities of equilibrium, particularly a hypersensitiveness to motion, are a hazard to the pilot and such conditions should be eliminated. For example after being turned to the right and the turning stopped, one has the sensation (if he cannot see the horizon) of turning to the left. If, therefore, a flier goes into a spin in a fog and comes out of it, he has the sensation of spinning in the opposite direction. He manipulates the controls to come out of his supposed second spin and of course goes into another. He becomes hopelessly confused and crashes. This probably accounts for some of the fatalities of the ocean fliers."

PRACTICAL GLEANINGS

Educationally, safety has come to the public schools to stay. Most interesting were the discussions on how safety education can be introduced and combined with the regular curriculum by the teacher. Some of the practical points gathered from all of these meetings which school nurses might well note are:

Pupils are given charge of traffic in school halls, playground equipment and vacation playground, and curb line help in the streets, but are not acting as traffic officers, which has proved dangerous.

See-saws, high swings, high slides should be eliminated from playground equipment as causing too many accidents.

In California every parent-teacher association has a safety committee studying the safety program. It offers a program for the whole parent-teacher association once a year.

Prompt dismissal of school children insures the gratitude of traffic officers, parents, and insures the safety of the child. Children should be shown dangers, introduced to traffic cop, understand safety lines, and zones on routes to and from school.

In Worcester, Massachusetts, as a result of safety education, in one and a half years not one of 53,000 school children has been killed going to or from school. Fifty per cent accident reduction was reported last year.

A black line twenty feet from wall of the gymnasium should be used as goal instead of the wall itself to prevent accidents.

Newer education has as its aim the effort to integrate the child's needs with the demands of the world. The conditions of the world today demand the education of the child for his safety.

ACTIVITIES *of the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

As we go to press a telegram from Mrs. Hansen announces that Miss Katharine Tucker has accepted the appointment of General Director of the N.O.P.H.N.

COMMITTEE APPOINTMENTS

In addition to the committee appointments by the Board of Directors already published, the following appointments have been made:

REVISIONS COMMITTEE

*Gertrude Bowling, Chairman	*Elizabeth Stringer	Marie T. Phelan
*Anna Ewing	Alice Bagley	Mrs. Kathryn Schulken
*Katharine Faville	Eula Butzerin	Helen Teal
*Winifred Fitzpatrick	Mary E. Davis	Hazel Wedgwood
*Anna M. L. Huber	Margaret East	Mrs. Helen D. Moore
*Winifred Rand	Mrs. Harold A. Marvin	Two to be appointed

* Executive Section.

SPECIAL COMMITTEE TO WORK WITH THE COMMITTEE ON THE REGISTRATION OF VITAL STATISTICS

Mary A. Brownell
Anna Ewing
Louise Tattershall

EDUCATION COMMITTEE

Additional appointment to personnel: Mary Beard

N.O.P.H.N. representatives on special committees are as follows:

Social Service Exchange Committee of the Association of Community Chests and Councils—Beatrice Short

Public Health Committee, General Federation of Women's Clubs—Mrs. Elena Crough Lockwood

Hospitality Committee of the International Council of Nurses—Mary S. Gardner, Elizabeth G. Fox, Edna Foley, Naomi Deutsch, Mrs. Elizabeth Soule

FIELD NOTES

Mrs. Hansen attended the Florida State Nurses Association meeting in Tampa and the meeting of the Georgia State Organization for Public Health Nursing. Mrs. Hansen was one of the principal speakers at both meetings. Expressions of appreciation of having the opportunity to confer with our President have been received in letters from nurses in the field.

Miss Tattershall, statistician, was in Washington, D. C., October 29–31, giving advisory service on records to and at the request of the Instructive Visiting Nurse Society.

Miss Carr represented the N.O.P.H.N. at the Seventh Annual Meeting of the American Dietetic Association held in Washington, D. C., October 29–31. Miss Carr, as a representative of the N.O.P.H.N., also attended the meeting of agencies interested in the promotion of the 1929 Negro Health Week called by the U. S. Public Health Service.

BOARD AND COMMITTEE MEMBERS' FORUM

Edited by VIRGINIA BLAKE MILLER
Vice-President, Instructive Visiting Nurse Society, Washington, D. C.

The Federation of Visiting Nurse Associations of Northern New Jersey held an all day Institute at the Town and Country Club, at Elizabeth, on October 23rd. Arrangements for the Institute were made by the Visiting Nurses Association of Elizabeth.

A short business meeting was held. At this meeting two interesting reports of the convention held at Louisville were given—from a board member's point of view, and from a nurse's point of view.

The president of the Elizabeth Visiting Nurses' Association introduced the speakers of the day. Miss Gertrude Peabody, Boston, gave the first address on Education of Board Members, which was discussed by Mrs. Whitman Cross, Washington, D. C. Miss Katherine Tucker, Philadelphia, added to the discussion on Education of Board Members and made a plea for a fuller study of mental hygiene in relation to the nursing service.

At the afternoon session it was announced that the January meeting of the Federation would be held the second Tuesday in January at Newark. Dr. Armstrong of the Metropolitan Life Insurance Company and State Board of Health spoke on The Responsibility of Private Health Organizations in Community Program of Health. This was discussed by a member of the State Medical Board. Mr. Richards, the Elizabeth Health Officer, and Mrs. C.-E. A. Winslow of New Haven also spoke.

Nearly 200 members of the Federation were present.

MARGARETTA N. AUTEN, *Secretary*

The following day the committee preparing a Board Members' Manual under the auspices of the Board and Committee Members Section of the N.O.P.H.N., who had been invited to attend the Institute, held a committee meeting. During the summer considerable progress has been made on the Manual and it is hoped that early in 1929 a tentative draft of the complete Manual may be ready to send out to the advisory committee for criticism.

PUBLICITY IN PUBLIC HEALTH NURSING ASSOCIATIONS

(*Continued from November number*)

In 1926 the Evansville Public Health Nursing Association (withdrawing from the Community Chest) made a direct appeal to the citizens of the city and county for funds for maintenance.

The merchants were asked to use window displays, which they did gladly. One window used living models, nurses and patients being used for the demonstrations. One merchant reproduced the actual room of one of our patients. The family had covered the walls with newspaper to hide the dirt that a baby might be born with some degree of cleanliness. We had taken a picture of this room for our files. It made a very effective window. Our main business street had a banner hung from each electric light post for eight blocks, each with a different slogan, similar to these: "Twelve cents buys a quart of milk," "Help the aged," "We need $28,000.00," "Save a baby." These signs were put up by a local decorating company, the Public Utilities Company permitting us to use the poles. The cost of the signs was very small, as the material was bought at wholesale prices and the painting done very cheaply. The Public Utilities Company gave us our first newspaper space for advertising our campaign, 50 inches in each of the local papers. We also used the street car sign-boards

Communications for this department should be sent to Mrs. G. Brown Miller, care of THE PUBLIC HEALTH NURSE, *370 Seventh Avenue, New York City.*

the week before the campaign, asking for the amount needed and announcing the date of the drive,

Handbills were distributed through the schools and factories showing what their money would buy, ranging from a $1,320.00 gift to a twelve cent gift. These slogans used on the hand bills were similar to those used on the street signs. Letters were sent to every lodge, fraternal organization and their auxiliaries, chain stores and main offices. Each letter contained hand bills. Speakers appeared at all the luncheon clubs.

One of the most effective publicity stunts was put on for the Rotary. The Junior League girls dressed in nurses' uniforms served the luncheon and one of them made a two-minute talk appealing for funds. Some crippled patients were brought by the nurses into the dining room. These cases made a lasting impression and we heard from this demonstration a great many times during the campaign from Rotarians.

We used a small motion picture trailer, using the slogans mentioned before. This trailer we placed in every motion picture house over the city. As we only had one trailer, every three days it had to be changed to a different section of the city. The week of the campaign it was shown in the two largest picture theaters in the down-town section.

We realized very early in the campaign the necessity of newspaper advertising. In order to get news space for our stories, it was essential that we use advertising space. We had no fund for this sort of publicity and the rates are high, so we conceived the idea of asking merchants using several thousand inches of advertising space a year on a low rate contract basis, to permit us to use their contract rate and resell the space to interested people. For instance, a full page advertisement at the transient rate would cost us around $180.00. This space we could buy for about ninety dollars on this low contracted rate. In some instances two or three people would come in on a page, thereby cutting down any great expense for one individual.

We used no names of persons contributing the advertising. This advertising was sold by a board member and also written by her. We used four full pages and two half pages. The newspaper columns were full of publicity of a constructive, educational type. This preliminary campaign material was prepared by the chairman of the Campaign Committee for the most part, so that all material was correct. We gave the history and growth of the organization, outlined the work carried on and gave interesting stories of various cases.

The campaign was over subscribed. We lost less than 1 per cent of the money pledged. This follow-up work of collecting pledges was in the hands of a very capable board member.

Because our fund was over subscribed in 1926 and a county fund became available January, 1927, we were able to eliminate our drive in 1927. In our campaign for this year we are using the same general outline of publicity. Our film will be larger and of the motion type showing two branches of our work with a few stills of headquarters. Instead of using the hand bills in the schools, we have received permission from the school board to conduct a "Slogan Contest" with two prizes. The child writing the best essay about the Evansville Public Health Nursing Association and giving the best slogan for our campaign will be awarded first prize. This contest will be a part of their English and health work. The newspaper advertising will be sold as before as we have made all arrangements with the advertising managers early in the summer. We hope to use the radio this year and this time will be solicited in the same manner as the newspaper space.

We pay no outside agency to assist us. The board members, assisted by the Junior League, do all the work. The allocating card system will be used in selecting names with a selected committee in charge of the large donations. We have no luncheons for workers' reports. The solicitors take their cards in the morning and work as long as possible and report back to headquarters when finished. We have an office personnel made up of Board Members familiar with campaign procedure. Our soliciting closes definitely the last day of the week selected for the drive. The Junior League girls will have milk cans on every corner in the down-town section the closing night of the campaign. We realized several hundred dollars in small change with these cans. We use a great many posters in our campaign headquarters. This we establish in the business district. We are looking forward to a successful campaign this year.—*Evansville, Ind., Public Health Nursing Association.*

Before the war the Visiting Nurse Association of Minneapolis was financed by an annual Tag Day—wearing, indeed almost prostrating, but in itself excellent publicity. With the war came the need for more efficient methods of raising money, as the work increased and one dollar had to do the work of two.

The Community Fund now takes the place of Tag Day, and in one week raises the money for the support of the various relief agencies of the city. At that time the Association makes the greatest possible effort concretely to present itself to the public. Members of the board and of the staff speak in the theaters, address schools, women's clubs, factories, do everything to popularize the work. Displays accenting various phases of the service are shown throughout the week in downtown shop-windows. A film sponsored by the Council of Social Agencies is shown in city picture houses, giving a graphic account of activities of the various organizations. This year the stress is to be on the work of the Visiting Nurse Association.

We have been fortunate in the coöperation of the medical profession, dentists and druggists. These we have supplied with small cards giving general information, the type of service, the charge, hours, etc. The cards, and larger leaflets with more detail, are distributed at meetings where talks are given on the work of the Association. Letters are frequently written to various professional and business institutions who might find our services useful. Newspaper articles on the service of the organization are published from time to time. We have been fortunate in having the assistance of the publicity adviser to the social agencies in the Community Fund.

In general publicity every member of the Association from the president to the youngest staff nurse, is actively interested. In their various circles they spread the work and add immeasurably to the popularizing of the service. Given a sound, effective organization, working at its best three hundred and sixty-five days in the year—it is its own best publicity.—*Visiting Nurse Association, Minneapolis, Minn.*

The December issue of THE PUBLIC HEALTH NURSE is as usual devoted to problems of maternity and infancy and therefore must be of special interest to board members who are constantly confronted with the difficulty of providing adequate maternity service and are faced with an ever growing sense of responsibility to promote this vital form of nursing care.

One of the three Christmas cards issued by the International Grenfell Association. This design, in black and white, was drawn by Sir Wilfred Grenfell—the card sells for 5 cents. "North of 53" in colors, 10 cents. "Christmas Eve on the Labrador" in colors, 15 cents. These cards are sold for the benefit of the children of the Mission in Labrador and Newfoundland, and may be obtained from the Association, 156 Fifth Avenue, New York City.

POLICIES AND PROBLEMS OF PUBLIC HEALTH NURSING

How can tuberculosis nursing and education of the public in prevention of this disease be made a part of a general public health nursing program?

Tuberculosis is so much a problem of every age group and so closely allied with all community health problems that it is hard to imagine a good general health nursing program that would not consider tuberculosis nursing one of the first essentials for which to provide. East Harlem Nursing and Health Demonstration in the pamphlet, "Standards for Tuberculosis Work in a Generalized Nursing Program" has given specific standards for such care. An article by Violet Hodgson in THE PUBLIC HEALTH NURSE for October, 1927, entitled "Tuberculosis Nursing in a General Program" also discusses this question.—*Katharine Faville, Association for Improving the Condition of the Poor, New York City.*

I believe that tuberculosis nursing and education of the public in prevention of this disease can certainly be made a part of a general program, but one must have constant advertising, and clinics—not occasional, but at least once a month. I have two a month in my county. Here the people can come for examinations and advice from a tuberculosis specialist. They are always advised to return for examinations and in this way we can keep a check on their physical condition and those whom we find as contacts or suspects.

We carry on the Health Crusade; each month I type and run on the mimeograph a good sized program for the teachers. This is made up of health suggestions, poster work, poems, stories and pictures. It takes time, but I have harvested results from it which I feel are lasting. In school examinations I pick out the children from their histories and advise their parents to bring them to the tuberculosis clinic. I supply sputum containers and also containers for sputum examinations and make home calls of instruction. The commission now allows 11 beds in one sanatorium, three in another. Perhaps later from reports of cases cared for they will see the necessity for a sanatorium of our own. About 200 cases are being looked after, and advised. It is fascinating and a worth while work.—*Elkhart County Nurse, Goshen, Indiana.*

Tuberculosis nursing, that is, follow-up work and the watching of contacts does make up a large part of all the nursing programs I know anything about. Nutrition work as a preventive is newer, but we are trying it out in both the grade school and the high school with fairly satisfactory results here. The only thing I can see for public education is to grasp every opportunity and to keep eternally and forever at it.—*Eva R. Jackson, R.N., American Red Cross Public Health Nurse, Sedro-Woolley, Wash.*

THANK GOODNESS!

Two county nurses were discussing "shop" and nursing field representatives.

"Do you remember the demonstration of Bag Technique at the last section meeting of public health nurses?"

"Yes. It was all right for a big city service—but it is a nuisance for nurses working alone the way we do—driving cars and doing educational work most of the time."

"But, my dear, that is just where you are wrong. Let me tell you of my experience a month ago.

"You know I had been letting my technique slide a bit until that meeting. But, thank goodness, the demonstration and talk about the aims of a bag technique jacked me up just in time to keep me from getting into a sorry mess.

"One morning, the M. L. I. agent called me to visit a policyholder of his. 'Kidney trouble of some sort,' he said. Well, I went in using a bag technique such as Miss —— demonstrated. The patient's husband said the doctor was not sure of the diagnosis but

thought that it was diabetes. I gave her full care—bath and everything. I noticed that she had pimples on her face but did not think much of it. I departed to go to an emergency post partum and new-born—one day old—and to three other cases that day.

"The next morning as I drove up to the door I noticed a placard on the house. 'Why, how unobserving I was not to notice that "For Sale" sign yesterday,' I thought. But it was not a 'For Sale' sign staring me in the face. It was a smallpox quarantine! I just naturally never did stop that car until I was miles away. All I could think of was, 'Smallpox, and I took no precautions! Smallpox and I went directly to a new post partum!' Finally I began to recall what I had done in that house.

"Yes—I had left the bag outside the patient's room—I had scrubbed my hands before entering the bag—I had cleaned the thermometer first with green soap and then soaked it in an alcohol pledget (I had used that same thermometer on the post partum case and the others. Just think of it!)—I had scrubbed my hands thoroughly with green soap after completing care. Just the routine bag technique that I use on every bedside case. The apron was the only possible serious break in a communicable disease technique and some how or other I felt that it had not been contaminated—though, of course, I would have left it in the room had I even suspected a communicable disease.

"'Thank goodness,' I thought, 'I used a good bag technique and they said that it was pretty nearly fool proof!'

"After that I rested more easily. None of my patients developed smallpox.

"No, don't you tell me that bag technique is not for us nurses working alone. All the time that I have put into bag technique is worth the peace of mind it gave me that morning and since to know that, undoubtedly, that technique was the only thing that saved me from starting an epidemic in that town."

"Will you show me that bag technique again?" asked the "Doubting Thomas" nurse!—*Indiana State Bulletin.*

We are indebted to the *Red Cross Courier* for the following letter which the Wheeling (West Virginia) Red Cross Chapter sends to each prenatal patient's doctor when she is taken under supervision by the Red Cross visiting nursing staff:

My dear Doctor: Mrs. ..... at ..... Street, who has engaged you for her care at delivery, has been referred to this association for prenatal instruction and nursing care.

In order to make the work of the nurses of this association of a uniformly high standard, the Medical Board has adopted the enclosed routine for the nurses to follow.

May we not have your coöperation in our effort to teach the women of the community the need for and value of medical supervision throughout their pregnancy?

May we have your permission to instruct our nurses to visit Mrs. ..... in accordance with our routine, and report any abnormal condition to you?

A prompt reply will be greatly appreciated.

Cordially yours,

.....

Supervisor of Nurses

Approval: .....

A Cod Liver Oil Cocktail which meets with the approval of Milwaukee babies has been sent us by the Milwaukee Visiting Nurse Association:

Two tablespoons of orange juice
Two tablespoons of water
One-half teaspoon of Karo syrup
One teaspoon of cod liver oil

RED CROSS PUBLIC HEALTH NURSING

Edited by ELIZABETH G. FOX

When the California Air Race Association was planning for the National Air Races to take place September 8 to September 16, at Mines Field, and the question of caring for casualties among civilian fliers and possible injuries to spectators arose, the coöperation of the American Red Cross was immediately asked, and as quickly granted. The original intention was to have an Army Hospital to care for Army fliers, a Naval Hospital to care for Naval fliers, leaving the civilian contestants as well as the enormous crowds to the Red Cross. The final arrangements left the equipment and maintenance of one large central Field Hospital to the American Red Cross, assisted by volunteer doctors from both Army and Navy as well as the civilian doctors who had volunteered for Red Cross Service, and under the immediate direction of the Los Angeles Chapter Director of Home Hygiene and Care of the Sick, with the head of the Culver City Community Hospital acting as surgeon in charge.

The hospital was fitted up from the Los Angeles Red Cross disaster relief equipment, which is sufficient to fit out a 100-bed hospital at very short notice. Six tents of this equipment were used—one large one with surgical, dressing and instrument tables, cots and all the necessary equipment for emergency treatments; a second tent with eight cots, used for patients suffering from shock or resting after minor injuries and awaiting removal to their homes; a third small tent for hospital supplies, and three adjoining tents fitted up with twenty-five cots for the use of the guard quartered there by the United States Regular Army. Two doctors and two nurses were on duty constantly from 9:30 A.M. until 11:00 P.M. in the hospital itself, aside from those in attendance at the different points in the field.

There were five ambulances in constant attendance—one stationed beside the hospital, one at each of the three Pylons, and another in front of the grandstand. A doctor was with each ambulance and eighteen first aid men were stationed at various points around the field. Owing to the presence of so many contestants, so much traffic, and such masses of people everywhere, it was necessary to assign a motorcycle policeman to each ambulance also, in order to clear a way for it when emergency calls were turned in. A motorcycle and side car equipped with bolt cutters and a Pyrene extinguisher was kept in readiness for aeroplane crashes, and played a very important part in releasing one of the aviators from his demolished plane.

Although the medical and first aid staff was large, everyone spent a very busy week, and the preparedness program was none too extensive. The very first case was brought in while the hospital was in the process of preparation—a young mechanic suffering from severe cuts on one hand, having caught it in an electric fan. He was quite proud of the fact that he was the first patient, and came back every day for a dressing.

The second day of the races, the necessity for the hospital was brought home forcibly when one of the racing planes crashed, the flier, Hasselman, suffering severe scalp wounds as well as other injuries. He was given first aid treatment at the Field Hospital and rushed to the receiving hospital at Culver City, where he remained for six days. At the end of that time, the Field Hospital ambulance brought him back to Mines Field where he was placed on the hospital plane and taken to the Army Hospital at San Diego. He was expected to recover.

The following day one of the flying trio known as the "Three Musketeers"

crashed and was fatally hurt. All was done that could be done, but his life could not be saved.

With such a beginning, the hospital staff rather expected a heavy week, but fortunately there were no more accidents of this kind, although there were plenty of the less serious ones. A member of the National Guard came in for treatment very much chagrined, as well as covered with blood, confessing that he had been thrown from his horse. He was suffering from a severe gash in the cheek and had one ear almost torn off. He was glad to receive immediate treatment for his painful, if somewhat inglorious wounds.

The various activities in connection with so large an undertaking as the National Air Races provided the hospital with a number of cases. Chief of these was the hot dog stand. The employees there frequently suffered more or less painful cuts while preparing the "dogs," especially the youngsters who sold them around the field. One of these young lads brought in a fresh cut so frequently that one of the doctors jokingly assured him that he could not have another cut dressed unless he brought him in a "hot dog." A couple of days later he came in again, bleeding profusely, and before the doctor could even begin, the youngster piped up, "Say, Doc, I couldn't get you a dog, but I swiped you three bags of peanuts."

Among the aviators, the parachute jumpers were the most frequent patients. They suffered from sprains of various kinds, finger, wrist, and ankle, as well as severe skin abrasions. They often had bruises and sometimes broken bones, but their wonderful spirit was one of the remarkable features of the Exposition. While the injuries from one jump were being dressed, they spoke quite casually of their next one, as if it were anything else but a wonderful feat.

One and all of the patients were most grateful for the treatment given, and most of them were agreeably surprised when they were informed that it was gratis.

Besides the Emergency Hospital, a First Aid Station was maintained in the Exposition Building in charge of a volunteer worker of the Los Angeles Chapter of the American Red Cross. Two of the Red Cross Home Hygiene and First Aid graduates were in attendance. Although all serious cases were sent to the hospital, 56 cases of minor cuts, bruises, headaches, and faints were taken care of here.

This First Aid program not only filled a great need at the scene of the races, Mines Field, but demonstrated the fact that the American Red Cross is at all times prepared for emergency service of any kind, either in war or peace.

MATILDA HARRIS
Director, Pacific Coast Division, American Red Cross Public Health Nursing Service

The Maryland State Department of Health is sending out to parents as soon as the facts of birth have been duly recorded a finely engraved certificate showing that their child has been legally registered as a citizen.

The certificate shows the Great Seal of the State and is signed by the Director of the State Department of Health. It is of a size suitable for framing and takes the place of the smaller certificate used by the Department.

REVIEWS AND BOOK NOTES

Edited by DOROTHY DEMING

FAMILY LIFE TODAY

Edited by Margaret E. Rich

Houghton Mifflin Co., 1928. 239 pp. $2.50.

(Papers presented at a conference in celebration of the fiftieth anniversary Charity Organization work in America, held at Buffalo, in October, 1927.)

That the family as a satisfactory and permanent social institution has been challenged, we all know. Rarely have we had so many worthy reflections on this subject as are brought together by Margaret E. Rich in *Family Life Today*. Any public health nurse who has not already read this book will quicken her social consciousness by doing so. Here we have a record of the thoughts of fourteen eminent authorities—biologists, sociologists, ministers, teachers, social workers, industrial authorities—on the problems of family life today and possible evolutionary trends. Here we have a wealth of wisdom.

Herbert S. Jennings, the biologist, tells us that the "diversified and exacting life career of man appears to be met most adequately (though obviously still imperfectly) by the lifelong monogamous family." W. F. Ogburn, the sociologist, sees the family as the great protector and transmitter of the social heritage, as the fountain source of affection which produces happiness—"not a really bad thing, after all," he opines.

Ernest R. Groves sees that our next step is education for parenthood and family life—not education by means of a set of rules, but education which will give young men and women a "basis for insight." Mary E. Richmond assumes that "a new and separate movement for saner, more truly permanent, more socially successful marriage is soon to get under way," and sees that doctors, lawyers, clergymen, lawmakers, women's organizations, scientists and social workers all are needed in the crusade.

Far from bemoaning the reaction of the family to the machine age, Frederick Eliot feels that "power is sufficient to surround the family with an environment far more rationally planned and far more wisely controlled than has ever been possible in the past." David C. Adie is sure that all daily effort to give help to individuals, to specific factories, to definite problems, will accomplish more perhaps than general schemes of reform—this gives us courage for our small daily tasks and hope for a better social order.

Indeed, all through the book is hope. The consensus of opinion seems to be that the family is still the most stable social unit, still more stable than unstable and with the transforming of thought into action, the family will survive, keeping the riches of the past and adjusting to the opportunities of the present and the future.

ALTA ELIZABETH DINES

PRINCIPLES OF TEACHING IN SCHOOLS OF NURSING

By Sister John Gabriel

The Macmillan Company, New York. 1928. $2.00.

The public health nurse with a growing consciousness of her responsibility as a teacher turns an interested ear to sources of information which may strengthen her educational work. Possibly she may find just the help she needs in this well written text.

The author has gathered together the writings of many well known educators and has prepared, in a well organized whole, the principles of teaching as applied to the nursing field. Although the text is written for the teacher in the nursing school and is designed for classroom teaching, it should also be useful to other nurse educators. The public health nurse conducting classes in nursing and hygiene may apply the principles as outlined directly to her work. The educational director or supervisor in public health nursing will find the book useful in planning her work and the staff nurse may benefit directly in her home teaching through a study of the principles of teaching as outlined.

Each step in the educative process

has been taken up under chapter headings and a very inclusive but short summary is made of each chapter.

CLARA B. RUE

THE MATERNITY SERVICE REPORT OF THE EAST HARLEM NURSING AND HEALTH DEMONSTRATION

354 East 116th Street, New York City. Price 25 cents

A Statistical Report Compiled from Medical, Nursing, and Nutrition Data Collected in a Five-Year Demonstration Period

This report is based upon analyses of record data collected in the routine care given to 1,978 maternity cases over a five-year demonstration period. That the service did not suffer from its inclusion as a part of a generalized nursing and health service, is evidenced in the results reported. An honest effort to measure the service rendered with the community need for service is evident. Maternal death rates are checked with case histories and death certificates.

The service reached 30 per cent of all mothers in the district who were delivered of living infants during the five-year period and absorbed one-fourth of all funds available for sickness and health activities.

Of the report, Dr. Haven Emerson writes: "It is an admirable record and interpretation." Dr. C.-E. A. Winslow comments: "I think this is one of the soundest contributions to a very complex subject and congratulate you most warmly on the way in which the material is handled and on the admirable results obtained."

A new *Directory of Psychiatric Clinics for Children in the United States* has just been issued by the Division of Publications of the Commonwealth Fund, 578 Madison Avenue, New York City. It includes, besides a list of the clinics providing regular service to the public for the study and treatment of the behavior problems of children, a description of institutional and other mental hygiene resources under state auspices, as well as the names, addresses and chief activities of state and local mental hygiene societies wherever such organizations exist.

In order to stimulate interest in books on public health a health book contest was run during the recent American Public Health Association Convention in Chicago.

According to the rules of the contest each delegate was asked to name "ten books on public health which you have found most helpful and which you could recommend to your fellow sanitarians."

These were the books receiving the greatest number of votes by the delegates:

Preventive Medicine and Hygiene—Rosenau
Newer Knowledge of Nutrition—McCollum
Health Survey of 86 Cities—American Child Health Association
Public Health and Hygiene—Park
Vital Statistics—Whipple
Publicity for Social Work—Routzahn and Routzahn
Child Hygiene—Baker
Public Health Nursing—Gardner
Epidemiology and Public Health—Vaughn
Health and Wealth—Dublin
Principles of Medicine—Osler

"The Preschool Days of Betty Jones" is the title of a new educational film strip prepared by the Children's Bureau for general distribution. The standards of care necessary for the mental and physical welfare of children from 1 to 6 years of age are illustrated in a series of pictures with explanatory captions.

A list of publications, exhibits, films and slides, with prices, on child welfare is obtainable from the Elizabeth McCormick Memorial Fund, 848 N. Dearborn Street, Chicago, Illinois. The Fund also maintains a loan library and will make up special bibliographies on child welfare on request.

Among the recent publications of the National Tuberculosis Association, 370 Seventh Avenue, New York City, are the *Tuberculosis Association Directory* and the *Tuberculosis Sanatorium Directory*. Through the generosity of the members of the Trudeau family and the coöperation of Doubleday, Doran and Company, a special edition of the *Autobiography of Dr. Edward Livingston Trudeau* is being published which will be for sale at $1.00 a copy.

" Within the Gates " is a new motion picture released by the Women's Bureau of the U. S. Department of Labor, picturing women not as the " world's greatest spenders " but as producers of much of the goods that all of us buy. One in every five workers is a woman, and for every four women who stay at home one goes into gainful employment.

As a concrete example of women's present-day participation in industry, the course of the entire textile industry is shown through the making of a single shirt from the picking of the cotton in the fields until a garment ready to sell across the counter is turned out.

The picture ends with an appeal that the eight and a half million women at work in this country be given a fair chance and good working conditions " for the sake of a greater America."

" Within the Gates " will be loaned by the Women's Bureau to responsible borrowers upon payment of express charges to and from Washington.

A useful non-technical guide for persons suffering from diabetes has been written by Dr. Henry I. John, Director of the Diabetic Department, Cleveland Clinic. *A Diabetic Manual for Patients*, published by the C. V. Mosby Co., St. Louis, Mo., price $2.00.

The New York State Department of Health is just completing the production of a new motion-picture film designed to show how milk becomes contaminated, and the possibilities of infection through impure milk. The film, which is popular and amusing, takes about five minutes to show and is mostly in animated-cartoon form. It will be loaned without charge for use in New York State, and arrangements have been made whereby agencies outside the state may purchase prints at a moderate price. For information address the Supervisor of Exhibits, 4 Clinton Ave., State Department of Health, Albany, N. Y.

A little book which just happened to come in time to be included in this Maternity Number is *The Midwife's Ante-Natal Clinic*, by Lelia Parnell, Matron of the British Hospital for Mothers and Babies, Woolwich, England. It is quite full of practical suggestions for nurses doing prenatal work. A very simple one, which at the same time is so thoughtful, we quote for the rural nurse:

" Time is often the great difficulty, and even with the best management there will come the horrid day on which the mother, having struggled perhaps up a steep hill, in order 'to see the nurse' for a conference, will be met by the sad little note on the table, 'Gone to a case.' Now I should plead for an addition to this note; if you can make it run 'so sorry; put the kettle on and make a cup of tea,' it will much soften the blow. The committee should be asked to allow half a pound of tea and some sugar to be kept in a little tin marked 'Mothers only.' These small courtesies are well worth while and country roads are long! "

A little pamphlet, " How to Adopt a Child," published by *Children—The Magazine for Parents*, 353 Fourth Avenue, New York, N. Y., may be purchased for twenty-five cents. It includes a list of reliable adoption agencies to which to apply in the United States.

" Santy Up to Date "

Hyar come Santy Claus a-flyin'!
Eagles hitch' ter his airy-plane!
Sleighs an' reindeers can't stand' de strain:
Skyscrapin' chimleys is too tryin'.

So out at pasture de deers is lyin';
Or under cover f'um snow an' rain;
While hyar come Santa Claus a-flyin',
Wid eagles hitch' ter his airy-plane!

No mo' fightin', and no mo' cryin';
De 'Merican Eagle is done got train'
Ter cross de ocean an' back again!
Totin' Santy Claus a'flyin'
Wid gif's fur all in his airy-plane!

—*Rosalie M. Jones*

NEWS NOTES

The Westchester County Organization for Public Health Nursing is sponsoring a series of ten lectures on public health. The first three lectures have already been given. The remainder of the program is as follows:

Thursday, November 8
SCHOOL NUTRITION
Mary Swartz Rose, Professor of Nutrition, Teachers College

Tuesday, November 13
SCHOOL NURSING
Mrs. Elmira Bears Wickenden

Tuesday, November 20
HOME NUTRITION
Frances Benjamin, East Harlem Nursing and Health Service

Tuesday, November 27
COMMUNICABLE DISEASE CONTROL
Dr. Haven Emerson, Professor of Public Health Administration, Columbia University

Tuesday, December 11
NURSING EDUCATION
Miss Lillian Hudson, Professor, Teachers College

Tuesday, December 18
SOCIAL HYGIENE
Miss Ann Doyle, United States Public Health Service

The course is open to the public, the cost for single lecture being $1.00 and for the full course of ten lectures, $10.00.

The Twenty-fifth Annual Meeting of the National Tuberculosis Association will be held in Atlantic City during the week of May 27, 1929. In deciding upon Atlantic City, the Board of Directors of the National Association took into consideration the fact that twenty-five years ago, in June, 1904, to be exact, the Association was formally organized in that city during the time of the American Medical Association's convention there. The appropriateness, therefore, of going back to Atlantic City for this twenty-fifth birthday meeting is obvious.

A series of eight mental hygiene lectures is being offered by the Henry Street Visiting Nurse Service, New York, between October 16 and December 10. The lectures are given in the evening by authorities in the field. For further information write to The Central Administration Building, 99 Park Avenue, New York.

Miss Gwendolyn Johnston, Public Health Nursing class of 1928, University of Oregon, has been granted one of six fellowships being offered to nurses by the Rockefeller Foundation. Miss Johnston's itinerary will include a six weeks' period at the Yale School of Nursing, also periods at Butler Hospital, Providence, R. I., Alabama State Department of Health and East Harlem Nursing and Health Service, New York City. Miss Johnston will return to the Loernbecher Hospital, Portland, Ore.

A new traveling mental-hygiene clinic was opened in Virginia on September 1 to serve the schools and the medical and social agencies in the various counties of the State and to examine and treat delinquent children, according to the recent announcement of the Virginia Commissioner of Public Welfare. The clinic was made possible by a contribution of approximately $40,000 from the Commonwealth Fund. Its staff will include a psychiatrist, a psychologist, and two psychiatric social workers.

Michael M. Davis, of New York City, has been appointed to the executive staff of the Julius Rosenwald Fund as Director of Medical Services.

Dr. Davis will direct the program which the Julius Rosenwald Fund is planning to undertake in improving the organized facilities for medical service to the average man of moderate

means. In these activities every effort will be made to coöperate with the medical profession. Special attention will be given to pay clinics.

The officers of the American Public Health Association elected for 1928–1929 are as follows:

President—George W. Fuller, 170 Broadway, New York City.
First Vice-President—A. J. Chesley, M.D., Old Capitol, St. Paul, Minn.
Second Vice-President—Norman MacL. Harris, M.B., Department of Health, Ottawa, Canada.
Third Vice-President—Louis E. Schmidt, M.D., 60 Bellevue Place, Chicago, Ill.
Treasurer—Edwin O. Jordan, Ph.D., University of Chicago, Chicago, Ill.

Of the Public Health Nursing Section:
Chairman—Grace Ross, Detroit, Michigan.
Vice-Chairman—Elizabeth Stringer, Brooklyn, N. Y.
Secretary—Helen LaMalle, New York City.

Minneapolis was chosen as the place of the next annual meeting.

Cincinnati honored the memory of Dr. Hideyo Noguchi at a memorial service on November 18th. A joint committee representing the Academy of Medicine, the College of Medicine of the University of Cincinnati and the Public Health Federation, sponsored the memorial and prepared a program national in scope. Invitations were extended to federal and state government, the United States Public Health Service, American Medical Association, American Public Health Association, the Army and Navy, American College of Physicians, American College of Surgeons, the surviving members of the Yellow Fever Commission, the surviving members of the Typhoid Fever Commission and the medical and scientific schools of the country.

An official Red Cross aircraft relief signal code has been worked out by the Red Cross in coöperation with the Army Air Corps. The system is simple. Strips of cloth are laid on the ground in the form of one or more letters. The relief airplane, as it flies low, reads the message and carries it back to relief headquarters. By this means all ordinary contingencies are covered. For instance, "F" means "We need nothing"; "KV" by joining the Roman numeral "V" means five persons killed; "AA," bacon wanted; "FK," blankets wanted; "HA," tablets of adrenalin, and so on through a list of essential medical supplies. This system of signaling was worked out in the Mississippi Valley disaster last year with a tentative code, with further experience in the New England flood. But the new code is much more complete. To prevent its use by unauthorized persons, it has been copyrighted by the Red Cross. Incidentally, it illustrates the close relationship between the Red Cross and the government in disaster relief.

To develop a body of trained visiting teachers a nine-months course including field work under the supervision of an experienced visiting teacher is being offered by the National Committee on Visiting Teachers in coöperation with the New York School of Social Work and the Graduate School of Social Service Administration of the University of Chicago. A consultant service free to school superintendents and boards of education and certain scholarships for teachers wishing training as visiting teachers are being offered by the National Committee on Visiting Teachers of New York City.

APPOINTMENTS

Lillian T. MacKinnon, recently returned from Brazil, has been appointed to do a piece of public health nursing work in Porto Rico under the Rockefeller Foundation, in connection with the Porto Rico Department of Health.

Florence Miller as Educational Supervisor of the Springfield Nursing and Public Health Association, Springfield, Mass.

Mrs. Myra Cloudman as Nursing Field Representative, American Red Cross, for Texas.

Inez Cadel as Assistant Director of the Instructive Visiting Nurse Society, Washington, D. C.

Jennie M. Niemela as county nurse in Multnomah County, Oregon.

APPOINTMENTS—Continued

Miss Inone, one of the Japanese Red Cross nurses, is to be sent—under the auspices of the League of Nations—for a year's course of study in London.

The state meeting of the Arkansas State Organization for Public Health Nursing was held October 29–30. The following new officers were elected:

President—Eva Mae Connor
Vice-President—Elizabeth Hoetzel
Second Vice-President — Mary Emma Smith
Secretary—Esther Foster
Treasurer—Mrs. G. W. Reagan

CORRECTION

We wish to correct an error in our October number. Miss Gladys Adams should have been listed as Field Secretary of the Associated Tuberculosis Clinics of Greater New York.

Boyd Printing Company, Inc., Albany, N. Y.